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

PRINTED: 10/01/2009
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
	53A051	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 located on the top floor of a two story building of Type II (111) construction built in 1998. The facility was separated from the hospital by a 2-hour rated fire barrier wall. The building was equipped with a supervised automatic wet fire sprinkler system with an anti-freeze branch and an addressable fire alarm system.	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 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 facility smoke partition was maintained as a continuous membrane in one of three smoke compartments. The findings were: Observation on 9/15/09 between 10 AM and 3 PM revealed the following concerns: a. Several ceiling tiles (3 ft x 6 in) were missing over the doorway leading into the kitchen refrigerator. b. Part of the ceiling tile (3 sq in) was missing in the hallway next to the activities room.	K 012	The facility will ensure all smoke partitions are maintained as a continuous membrane in all smoke compartments by completing the following repairs: A. The ceiling tiles missing over the doorway leading into the kitchen refrigerator have been replaced. 10/07/09 RIC B. The ceiling tile with a 3" square hole has been replaced. 10/07/09 RIC Plant Operations Manager will monitor to ensure future compliance. 10/07/09 A quality monitoring tool will be implemented to ensure maintenance of continuous membranes in all smoke compartments. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 10/7/09

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.

Approved without changes on 10/14/09 [illegible]

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K 012	Continued From page 1 Interview with the facility maintenance manager on 9/15/09 at 2:48 PM confirmed the ceiling tile was missing.	K 012		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 2 smoke barrier doors were able to resist the passage of smoke. The findings were: Observation on 9/15/09 between 10 AM and 3 PM revealed the following concerns: a. One of two cross corridor doors near the activities room failed to close and latch in the frame upon three attempts. The door had a self closure device attached. b. One of two cross corridor doors near resident room 101 failed to close and latch in the frame upon three attempts. The door had a self closure device attached. Interview with the maintenance manager on 9/15/09 at 2:15 PM confirmed the doors needed to be adjusted.	K 027	The facility will ensure that all smoke barrier doors are able to resist the passage of smoke by completing the following repairs: A. The cross corridor doors near the activities room have been repaired so they latch in the frame by means of a self-closure device each time they are released. 10/07/09 B. The cross corridor doors near resident room 101 have been repaired so they latch in the frame by means of a self-closure device each time they are released. 10/07/09 The Plant Operations Manager will monitor to ensure future compliance. 10/07/09 A quality monitoring tool will be implemented to ensure smoke barrier doors will resist the passage of smoke. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
K 047	NFPA 101 LIFE SAFETY CODE STANDARD	K 047		

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K 047 SS=E	Continued From page 2 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 and staff interview, the facility failed to ensure one directional corridor exit sign was properly configured in one of three smoke compartments. The findings were: Observation on 9/15/09 between 10 AM and 3 PM revealed a hallway corridor emergency exit sign outside resident room #106 with both directional arrows illuminated. One arrow was appropriately pointed to a facility exit. The other arrow however was directed into resident room #106. Interview with the maintenance manager on 9/15/09 at 11:30 AM confirmed the arrow pointing into the resident room needed to be covered.	K 047	The facility will ensure that all directional corridor exit signs are properly configured to direct traffic to appropriate exit. A. The hallway corridor emergency exit sign outside room 106 has been repaired to show the direction to the exit doorway. The other directional arrow pointing the wrong way has been removed. 10/07/09 The Plant Operations Manager will monitor to ensure future compliance. 10/07/09 A quality monitoring tool will be implemented to ensure correctly configured exit signs. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
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 2 of 3 smoke compartments. The findings were:	K 062	The facility will ensure that all sprinkler heads are properly maintained in all smoke compartments by completing the following repairs: A. The two escutcheons in the laundry room have been replaced. 10/07/09 B. The gap between the escutcheon and the celing in the storage closet opposite resident room #107 has been repaired. 10/07/09 The Plant Operations Manager will monitor to ensure future compliance. 10/07/09	

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K 062	Continued From page 3 Observation on 9/15/09 between 10 AM and 3 PM revealed two sprinkler head escutcheons in the laundry room were missing. In addition, there was a gap between the escutcheon and the ceiling in the storage closet opposite resident room #107. Interview with the maintenance manager on 9/15/09 at 2:45 PM confirmed the two escutcheons were missing and one was coming away from the ceiling.	K 062	A quality monitoring tool will be implemented to ensure proper maintenance of sprinkler heads. The monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to maintain 1 of 12 portable fire extinguishers. The findings were: Observation on 09/16/09 between 10 AM and 3 PM revealed the encasement containing the ABC type of fire extinguisher on the wall opposite the administrator's office was not secured to the wall. Interview with the facility maintenance manager on 9/15/09 at 3 PM confirmed the fire extinguisher encasement needed to be secured. .	K 064	The facility will ensure that all portable fire extinguishers are maintained by completing the following repairs: A. The encasement containing the ABC type of fire extinguisher near the Administrator's office has been secured to the wall. 10/07/09 The Plant Operations Manager will monitor to ensure future compliance. A quality monitoring tool will be implemented to ensure maintenance of portable fire extinguishers. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
K 069 SS=E	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:	K 069	The facility will ensure that all cooking equipment is maintained in proper working order by completing the following repairs: A. The Utah Fire Equipment company will install a microswitch for proper shutdown. This work	

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K 069	Continued From page 4 Based on record review and staff interview the facility failed to ensure facility cooking equipment was maintained in proper working order. The findings were: Review of facility records on 9/15/09 at 9:48 AM revealed the biannual inspection of the facility kitchen cooking equipment was conducted on 8/13/08 and then again on 02/25/09 by Salt Lake City Extinguishing Systems Inc. Review of the inspection report revealed the "three ovens need to be wired to a micro switch for proper shutdown". Interview with the facility maintenance manager on 9/15/09 at 9:48 AM revealed the cooking equipment fire suppression system needed to be repaired.	K 069	will be completed by 11/01/09. 11/01/09 Plant Operations Manager will monitor to ensure future compliance. 11/01/09 A quality monitoring tool will be implemented to ensure maintenance of cooking equipment. This monitor will be completed and reported at the monthly QA/QI meeting.	11/01/09
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance 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 electric wiring was in compliance with the National Electric Code and to maintain the required 3 feet of work space in front of electrical equipment in 1 of 3 smoke compartments. The findings were: Observation on 09/15/09 between 10 AM and 3 PM revealed the end of a metallic cable under the kitchen garbage disposal had come away from the terminal end exposing two hot wires. In addition, observation during this time also revealed eight boxes of papers sitting on the floor in front of and blocking access to an electrical panel (NC-11-E) in the office opposite resident	K 147	The facility will ensure that electrical wiring is in compliance with National Electric Code and maintain 3 feet of work space in front of electrical equipment in all smoke compartments. This will be done by completing the following changes and repairs: A. The end of a metallic cable under the kitchen garbage disposal has been reattached to the terminal, covering the two hot wires. 10/07/09 B. The eight boxes of papers have been removed from in front of the electrical panel (NC-11-E). 10/07/09 Plant Operations Manager will monitor to ensure future compliance. 10/07/09 A quality monitoring tool will be implemented to ensure that	

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K 147	Continued From page 5 room 101. Interview with the facility maintenance manager on 9/15/09 at 10:28 AM confirmed the above observations.	K 147	electrical wiring is in compliance with National Electric Code. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	The facility will ensure that ABHS dispensers are not installed over or near an ignition source in all smoke compartments by completing the following changes: A. The ABHR dispenser that was installed directly over a GFI outlet which was directly located over a sink in the dining room has been relocated. 10/07/09 Plant Operations Manager will monitor to ensure compliance. 10/07/09 A quality monitoring tool will be implemented to ensure that ABHR dispensers are properly located. This monitor will be completed and reported at the monthly QA/QI meeting.	10/07/09
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed over an ignition source in 1 of 3 smoke compartments. The findings were: Observation on 9/15/09 between 10 AM and 3 PM revealed an ABHR dispenser was attached to the wall directly over an electrical outlet (GFI outlet) which was located directly over a sink in the dining room. Interview with the maintenance manager on 9/15/09 at 11:30 AM confirmed the location of the ABHR dispenser.			

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