STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING 01 - MAIN BUILDING B. WING _____	06/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 two story building of Type V (111) construction built in 1953 and 1986. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop in the attic and a zoned fire alarm system.	K 000	K 029 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. Areas will be separated from other spaces by smoke resisting partitions and doors. The kitchen dry storage room door was adjusted to latch automatically when the door is closed. This was completed on June 2, 2009.	
K 029 SS=E	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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated as required in 2 of 13 smoke compartments. The findings were: 1. Observation on 6/02/09 at 11:12 AM revealed the automatic closing device attached to the	K 029	The two unsealed water pipe penetrations in boiler room #1 have been sealed. This was completed by June 19, 2009 The Dietary Service Manager will communicate to maintenance any time the kitchen dry storage room door or any other door in dietary does not latch. The Director of Maintenance will maintain doors to latch properly and to seal all wall penetrations. Director of Maintenance will monitor for compliance FINDINGS FROM INSPECTIONS WILL BE REVIEWED W/ QA UNTIL THE ISSUE IS NOT OBSERVED 2X.	

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

Ross Nelson — Administrator — 6-24-09

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.

POC accepted w/ JoAnn Faust, DON, on 6/25/09.

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K 029	Continued From page 1 kitchen dry storage room door did not latch the door into its frame with three attempts. Interview with the maintenance director at the time of observation revealed kitchen doors were not routinely inspected by maintenance staff. Kitchen staff were supposed to notify the maintenance department when items or equipment were damaged. He further reported that the kitchen staff did not routinely inspect doors to ensure they properly latched. 2. Observation on 6/02/09 at 12:58 PM revealed boiler room #1 had two unsealed water pipe penetrations. The penetration diameters were 1/2-inch larger than the 1-inch pipes. Interview with the maintenance director at the time of observation revealed the water temperatures in both boiler rooms were inspected weekly, but the walls were not part of the routine inspection. He further reported that he was aware that hazardous areas were required to be smoke resistant.	K 029		
K 038 SS=E	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 egress pathways had adequate headroom in 2 of 13 smoke compartments. The findings were: 1. Observation on 6/02/09 between 10 AM and	K 038	K 038 Exit access will be arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 The magnetic hold-open device attached to the smoke barrier door near room #26 has been removed as it is no longer needed there. The two magnetic locks on the front doors have been moved to comply with this requirement. This was completed by June 12, 2009. Administrator and Maintenance are aware of the headroom requirement and will not allow anything to be installed that will restrict the headroom on any door. Administrator will monitor for compliance OBSERVATIONS/FINDINGS WILL BE REPORTED TO QA UNTIL ISSUE IS NOT OBSERVED 2X.	

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K 038	Continued From page 2 12:30 PM revealed the magnetic hold-open devices attached to the smoke barrier door near resident room #26 and the two front entrance doors did not have the required 6 foot 8 inch headroom clearance. The distance between the floor and the bottom of the magnetic locks on booth sets of doors was only 6 foot 5 inches. 2. Interview with the maintenance director on 6/02/09 at 10:08 AM revealed he was not aware of the aforementioned headroom requirement.	K 038		
K 050 SS=E	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 observation, staff interview and facility policy review the facility failed to ensure staff members were familiar with emergency procedures on 1 of 3 shifts. The findings were: 1. Observation of a fire drill on 6/02/09 at 2:28 PM revealed the first responder a certified nurse aide (CNA) walked into the room of fire origin and found a red flashing light. The CNA did not know what the light signified so she left the room to ask the safety officer what the light was for. The safety officer told her it represented a fire and to	K 050	K 050 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. All staff will be familiar with procedures and will be aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to a competent person who is qualified to exercise leadership. The Safety Officer is responsible for conducting the fire drills. The Staff Development Coordinator is responsible to orient all new employees to the fire drill policy and procedure. On June 8, 2009, the Safety Officer conducted an inservice for all staff where he taught them the fire drill policy and procedure including the purpose of the red light and what to do when someone sees it and to clear the halls of any obstructions. The Safety Officer will continue to conduct fire drills as needed until all	

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K 050	Continued From page 3 proceed with the fire protocol. The CNA walked to the front nurses' station and told the charge nurse a simulated fire was in room #108. The nurse paged Code Red over the intercom system, staff members started to close doors, but did not activate the fire alarm. The administrator had to activate the fire alarm system one minute after the overhead page. Nursing staff left two Hoyer lifts in the corridor of fire origin. The nursing staff also left a medication cart in the corridor adjacent to the front nurses' station. Interview with the first responder (CNA) after the drill, revealed she had worked at the facility for more than six months. She reported she had never seen the flashing light before while on duty or during her orientation. She was familiar with the fire policy, thought hesitant with her responses. Interview with the safety officer revealed the light was not being shown during orientation classes. 2. Review of the facility's fire response policy revealed the evacuation section stated: "Clear egress corridors of attended items to prepare for resident evacuation."	K 050	staff are trained and respond appropriately. Safety Officer will report results of each drill to the Administrator and the Administrator will monitor for compliance. This will be completed by July 1, 2009	
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 sprinkler heads were free of foreign material in 1 of 13 smoke compartments. The findings were:	K 062	K 062 Required automatic sprinkler systems will be continuously maintained in reliable operating condition and are inspected and tested periodically. The two sprinkler heads in the staff lounge will be replaced. Maintenance Director will make sure that all sprinkler heads that get painted or coated with a foreign material will be replaced.	

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K 062	Continued From page 4 Observation on 6/02/09 at 10:50 AM revealed two of five sprinkler heads in the newly remodeled staff lounge were covered with joint compound. Closer inspection revealed the operating elements and orifice rings were covered with dry compound. Interview with the maintenance director at the time of observation revealed the lounge remodel was completed in the beginning of May 2009. He further reported that he was aware sprinkler heads were required to be replaced if painted or coated with foreign material.	K 062	Administrator will monitor for compliance. ALL SPRINKLER HEADS WILL BE INSPECTED ANNUALLY & AFTER EACH REMODELING PROJECT IS COMPLETE.	7/01/09
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the	K 074	K 074 Draperies, curtains, including cubicle curtains, and other loose hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1. The four curtains in the staff lounge have been removed. This was done on June 2, 2009. Maintenance Director will make sure that no curtains will be hung that do not meet the provisions of 10.3.1. Administrator will monitor for compliance. THROUGH QUARTERLY ROUNDS. ANY FOUND CURTAINS W/OUT FLAME RETARDANT DOCUMENTATION WILL BE REPORTED AT Q.A.	

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K 074	Continued From page 5 facility failed to ensure curtains were flame retardant in 1 of 13 smoke compartments. The findings were: Observation on 6/02/09 at 10:52 AM revealed the four curtains in the employees' lounge lacked flame retardant documentation. Interview with the maintenance director at the time of observation revealed he was aware all loose hanging curtains were required to be flame retardant. He further reported there was no flame retardant documentation to review for the aforementioned curtains.	K 074		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the	K 143	K 143 Transferring of oxygen will only be permitted in an area that is separated from any portion of the facility wherin patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction. In an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring and in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the compressed Gas Association. The liquid oxygen tank was removed from room #29 and all oxygen is now being transferred in the designated oxygen storage room.	

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K 143	Continued From page 6 facility failed to ensure liquid oxygen transfer rooms were constructed with 1-hour fire rated construction in 1 of 13 smoke compartments. The findings were: Observation on 6/02/09 at 10:14 AM revealed a full tank of liquid oxygen was being stored in resident room #29. Inspection of the room revealed no residents were housed in the room. Inspection of the room's construction components revealed the door was only twenty-minute rated and the walls were only thirty-minute rated. Furthermore, the room was not equipped with mechanical ventilation. The room was not posted with signs that the transference of liquid oxygen was occurring within. In addition, the room was not posted with no smoking signs. Interview with the director of nursing at the time of the observation revealed liquid oxygen was being transferred in the area so that the nursing staff did not have to walk to the approved liquid oxygen transfer room. She further reported that she was not aware that transferring and storing of liquid oxygen could only occur in approved rooms with required construction type and safety equipment. Interview with the maintenance director at the same time revealed he was also not unaware of the safety requirements for liquid oxygen transfer.	K 143	An inspection of the building was done and all storage and transferring of oxygen is being done in the designated area. This was completed on June 2, 2009. Maintenance Director and Administrator will monitor for compliance. QUARTERLY ROUNDS WILL ENSURE LIQUID OXYGEN TANKS ARE NOT STORED OUTSIDE OF APPROVED ROOMS, ANY FINDS WILL BE REVIEWED AT Q.A.	
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 temporary wiring did not replace permanent wiring, failed to prevent	K 147	K147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 The left boiler in boiler room #3 will be plugged into an electrical outlet. Electrical wires will be run in conduit to an outlet box located at the back of the boiler.	

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K 147	Continued From page 7 equipment damage and failed to provide ground fault protected equipment in 3 of 13 smoke compartments. The findings were: 1. Observation on 6/02/09 at 10:46 AM revealed the left boiler in boiler room #3 was plugged into an orange extension cord. Interview with the maintenance director at the time of observation revealed he was aware extension cords were prohibited. He further reported the water temperatures of the boilers were inspected weekly, but electrical equipment was not routinely inspected. 2. Observation on 6/02/09 at 12:11 PM revealed the electrical cord to an oxygen concentrator in resident room #6 was damaged at the plug. Closer inspection revealed that the outer sheath was split and the inner wires were exposed. Interview with the maintenance director at the time of observation revealed electrical equipment was inspected quarterly by management staff. He stated last inspection occurred in February 2009. 3. Observation on 6/02/09 at 12:36 PM revealed the electrical outlet located below the sink in the beauty shop was not equipped with a ground fault circuit interrupter (GFCI) receptacle. The faceplate of the receptacle was not labeled to show it was GFCI protected. Interview with the maintenance director at the time of observation revealed he was also unsure whether or not the receptacle "upstream" was GFCI protected, and which would have provided protection for the noted receptacle. The maintenance director stated he was aware that all receptacles located within 6 feet of a water source were required to be GFCI protected.	K 147	The oxygen concentrator in room #6 was a rental and has been returned to the owner. The electrical outlet located below the sink in the beauty shop was not equipped with a ground fault circuit interrupter receptacle. This outlet has been replaced with a GFCI protected outlet. An inspection of the entire building was done by maintenance and there are no other faulty electrical plugs orextension cords in use. Department Managers and the Administrator will monitor for compliance. This K tag will be fully corrected by July 1, 2009. QUARTERLY ELECTRICAL INSPECTIONS WILL ENSURE COMPLIANCE. ANY FINDINGS WILL BE REPORTED TO Q.A.	