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

PRINTED: 12/22/2008
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
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

(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 single story building with a basement of Type V (111) construction built in 1965. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch under the canopies and a zoned fire alarm system.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.*	
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 the minimum required headroom in one of five smoke compartments. The findings were: Observation on 12/10/08 at 9:30 AM revealed the main entrance double doors were equipped with magnetic locking devices that did not have the required 6 ft. 8 in. headroom. The actual measurement from the floor to the bottom of the magnetic devices was 6 ft. 4 in. Interview with the maintenance director (at the time of observation) revealed he was unaware of the height requirement.	K 038	K-38 The locking devices for the front double doors will be replaced with a locking device that will allow for the appropriate headroom. The Administrator and Maintenance Supervisor have been informed and educated on the height clearance requirement. Appropriate locking devices allowing for appropriate height clearance will be placed on the South Solarium double doors. The chandeliers in the front lobby have been identified as being too low and will be replaced with more appropriate fixtures. The Maintenance Supervisor or designee will look through out the facility to validate that we are in compliance with the height clearance regulation and will correct any problems found. Construction on the exits will be monitored and reviewed for compliance of the height	1/05/09 ~~March 31~~ 2009

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

EXECUTIVE DIRECTOR 1/5/09

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. 2009

POC MODIFIED & ACCEPTED W/ CHRISTANSEN, RD, 1/12/09.

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K 052 SS=F	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 record review and staff interview the facility failed to ensure 6 of 6 fire alarm system components were tested as required. The findings were: 1. Review of the fire alarm system testing records revealed the annunciator panel, annunciator batteries, notification appliances, manual fire alarm boxes and smoke detectors had not been tested in the past year. The aforementioned devices were last tested on 10/19/07. 2. Review of the fire alarm system testing records revealed the smoke detector sensitivity test had not been conducted in the past two years. The test was last done on 7/07/05. 3. Interview with the maintenance director on 12/09/08 at 5 PM revealed he thought the fire alarm system only had to be tested once every two years.	K 052	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.* requirement. The Maintenance Supervisor or designee will report to the PI Committee on the replacement of the existing locking devices and any new construction that is being done on the exits. The PI Committee will review for compliance and the decision for any further need of reports or audits will be determined. Correction Date : March 31 2009 K-052 The annunciator panel, annunciator batteries, notification appliances, manual fire alarm boxes and smoke detectors were tested on Dec 16 2008. The annunciator panel, annunciator batteries, notification appliances, manual fire alarm boxes and smoke detectors will be tested annually for compliance. Maintenance Supervisor and Administrator have been educated on the annual testing required for the annunciator panel,	Jan 12 2009
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=F	Continued From page 2 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 record review and staff interview the facility failed to ensure the sprinkler system was tested every quarter. Testing was not done during 1 of 4 quarters in 2008. The findings were: 1. Review of the sprinkler testing records revealed the main drain and waterflow device were not tested during the first quarter of 2008. 2. Interview with the maintenance director on 12/09/08 at 5 PM revealed the sprinkler system components had not been tested as required because the water was discharged onto sidewalks, and the outside temperature was cold enough to freeze the water and cause a slipping hazard.	K 062	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.* annunciator batteries, notification appliances, manual fire alarm boxes and smoke detectors The Maintenance Supervisor will monitor paperwork provided by the vendor who performs the annual tests and will document the completion. At the completion of the annual test, the maintenance supervisor will review the results with the Performance Improvement Committee. K-62	Jan 12 2009
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, blue print review and staff interview the facility failed to ensure exit access that would not require a return through the compartment of fire origin for all rooms in one of five smoke compartments as required by Section	K 130	The main drain and waterflow device will be tested quarterly. The last test was done 11/03/2008 so the next test will be done in Feb 2009. A hose has been purchased so that the water can be diverted from the sidewalks so that quarterly test can be completed without creating a hazard. The Maintenance Supervisor will be re-educated on the requirement of quarterly testing of the fire sprinkler system.	

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K 130	Continued From page 3 19.2.4.3. The findings were: Observation on 12/10/08 at 9:50 AM revealed the business office was in the west smoke compartment and did not have an exit access door into the smoke compartment of origin. The corridor door to the business office was in the smoke barrier wall and opened into the east smoke compartment. Blue print review with the maintenance director at the time of observation confirmed the business office was located in the west smoke compartment.	K 130	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.* The Administrator or designee will audit quarterly testing to validate the compliance of the quarterly testing of the fire sprinkling system.	
K 161 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure only one dumbwaiter door could open at a time in 2 of 5 smoke compartments. The findings were: Observation on 12/09/08 at 3:50 PM revealed the first floor door to the dumbwaiter was open while the basement dumbwaiter door was also open. With both doors open at the same time the shaft would not be 1-hour fire rated. Interview with the maintenance director at the time of observation revealed he was unaware that both doors could not be open at the same time. He further reported that he was unaware when the basement door had been replaced with a standard hinge-type door. The new basement door lacked a mechanism for locking the first floor door in order	K 161	The quarterly audits will be reviewed by the Performance Improvement Committee. It will be determined if there is further need of audits or reports. Completion Date: Jan 12 2009 K-130 The smoke barrier wall will be modified so that the office door will not be in the smoke barrier wall. Exit accesses will be reviewed to validate that they are in compliance with the smoke barrier wall requirements any problems found will be corrected. The Maintenance Supervisor will notify the PI Committee of the newly constructed smoke barrier wall and the compliance of the other exit access doors. Correction Date: April 30 2009	1/05/09 ~~April 30 200~~

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K 161	Continued From page 4 to prevent it from being opened whenever the basement door was open.	K 161	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.* K-161 The dumbwaiter doors on the first floor and the basement will be replaced with doors that have a locking mechanism for when one door is opened the other door will lock and remain closed until the opened door is closed. The Administrator and Maintenance Supervisor have been educated on the requirement of the dumbwaiter doors. At the completion of the replacement of the dumbwaiter doors the Maintenance Supervisor or designee will validate that only one door can be open at a time. Monthly audits will be completed for 6 months to validate that only one door can be open at a time. The completed audits will be reviewed by the Performance Improvement Committee. It will be determined if there is a need for further audits or reports. Completion Date: April 30 2009	1/05/09 ~~April 30 200~~