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

PRINTED: 07/17/2009
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
	535036	A. BUILDING 01 - MAIN BUILDING B. WING	07/08/2009

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

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K 000	INITIAL COMMENTS Requirements for the 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 sprinklered 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 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 smoke partition was maintained as a continuous membrane in 2 of 5 smoke compartments. The findings were: Observation on 7/7/09, between 11:30 AM and 3:00 PM, revealed five penetrations in the ceiling (each less than 1-inch in diameter) in the following locations: in the business office, a housekeeping closet next to the back nursing station and by the conference room. Interview with the facility's maintenance manager at the time of the observation confirmed the openings in the smoke barrier needed to be caulked.	K 012	K-012: The Maintenance Director or designee will repair the holes in the ceilings located in the business office, at the back nurse's station, and by the conference room. The Maintenance Director or designee will conduct a facility-wide audit to confirm that all ceilings in the facility are without holes. The Maintenance Director will incorporate into the preventative maintenance schedule the visual inspection of all ceilings to confirm that they are without any holes. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that all walls and ceilings are without holes. Results of the random audits will be presented to the QA&A committee monthly for 3 months Date of compliance is August 10, 2009.	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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

Exec Dir. 7/28/09

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/ changes, w/ Yvonne Yates, NHA, DN 7/29/09.

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K 018 SS=D	Continued From page 1 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. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a corridor door was capable of resisting the passage of smoke in 1 of 5 smoke compartments. The findings were: Observation on 7/7/09 between the hours of 11:30 AM and 3 PM revealed the corridor door to resident room #9 did not close tightly into its frame. Interview with the facility's maintenance manager at that time confirmed the door would require an adjustment in order to seat properly into its frame.	K 018	*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-018: The Maintenance Director or designee will repair the door in Room #9 to confirm that the door will properly close into its frame. The Maintenance Director or designee will incorporate into the preventive maintenance schedule an inspection log to confirm that all doors shut properly. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that doors shut properly. Results of the random audit will be presented to the QA&A Committee monthly for 3 months. Date of compliance is August 10, 2009.	
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 047	K-047: On 07/07/09 the Maintenance Director or designee replaced all burnt out light bulbs in the following exit signs: the sign over the facility exit # 3(facility chapel), #7 (by room #47), the sign over the facility's main entry and the sign in the hallway near the main entry.	

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K 047	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 four emergency exit signs were fully illuminated. The findings were: Observation on 7/7/09 between 11:30 AM and 3 PM revealed burned out light bulbs in the following emergency exit signs: the sign over the facility exit #3 (by the facility chapel), the sign over the facility exit #7 (by resident room #47), the sign over the facility's main entry and the sign in the hallway near the main entry. Interview with the maintenance manager at the time of the observations confirmed the burned out condition of the light bulbs in the identified exit signs.	K 047	*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 Maintenance Director or designee will conduct a facility-wide audit to confirm that all exit signs are fully illuminated. The Maintenance Director will incorporate into the preventive maintenance schedule a facility-wide inspection to determine that all exit signs are fully illuminated. Random audits will be conducted monthly, for 3 months by the Maintenance Director or designee to confirm that all exit signs are fully illuminated. Results of the random audits will be presented to the QA&A Committee monthly for 3 months. Date of compliance is August 10, 2009.	
K 052 SS=E	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	K-052: The Maintenance Director or designee will schedule a semi-annual battery load voltage test for the annunciator panel. The Maintenance Director will incorporate into the preventative maintenance schedule an inspection log to confirm that there have been semi-annual battery load voltage tests done.	

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K 052	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 9 fire alarm system components was tested as required by NFPA 72. The findings were: Review of the fire alarm system testing records revealed the semi-annual battery load voltage test for the annunciator panel was not performed within the previous six months. Documentation showed the batteries were last tested on 12/16/08 during an annual inspection. Interview with the maintenance manager on 7/7/09 at 10:50 AM revealed he was unaware the batteries were to be tested every six months.	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* Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that the semi-annual battery load voltage test has been conducted in a timely manner.	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and staff and resident interview the facility failed to ensure portable space heaters were not in use in 1 of 5 smoke compartments. The findings were: Observation on 7/7/09 between at 3:30 PM revealed a portable space heater was plugged into an electric outlet in resident room #10. Interview with a CNA at the time revealed the resident sometimes got cold and used the heater. The resident stated in an interview at the time of	K 070	Results of the random audits will be presented to the QA&A committee monthly for 3 months. Date of compliance is August 10, 2009. K-070: The Maintenance Director or designee will remove the portable space heater in resident room #10. The Maintenance Director or designee will conduct a facility-wide audit to confirm that there are no portable space heaters being used in the facility. The Maintenance Director will incorporate into the preventative maintenance schedule the inspection of all resident rooms to confirm that they are without portable space heaters.	

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K 070	Continued From page 4 the observation that he/she had anemia and sometimes used the space heater because he/she was cold. Interview with the maintenance manager at the same time confirmed the presence of the space heater in the resident's room.	K 070	*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 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure its electrical wiring was in compliance with the National Electric Code in 1 of 5 smoke compartments. The findings were: Observation on 7/7/09 at 3 PM revealed one wall-mounted electrical outlet was not protected against water exposure. The outlet was located less than 6 feet from an operational sink located on the counter behind the main nurses' station. The outlet was not GFI (ground fault interrupt) protected. Interview with the maintenance manager at the time confirmed the above observation.	K 130	Random audits will be preformed monthly for 3 months by the Maintenance Director or designee to confirm that there are no portable space heaters. Results of the random audits will be presented to the QA&A committee monthly for 3 months Date of compliance is August 10, 2009. K-130: The Maintenance Director or designee will replace a wall mounted electrical outlet on the counter behind the main nurses' station with an outlet that is GFI (Ground Fault Interrupt) protected.	
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 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 in 1	K 147	The Maintenance Director or designee will conduct a facility-wide audit to confirm that all electrical outlets within 6 feet from an operational sink are protected with a GFI outlet. The Maintenance Director will incorporate into the preventative maintenance schedule the inspection of all outlets to ensure they are protected with a GFI outlet if less than 6 feet from an operational sink.	

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K 070	Continued From page 4 the observation that he/she had anemia and sometimes used the space heater because he/she was cold. Interview with the maintenance manager at the same time confirmed the presence of the space heater in the resident's room.	K 070	*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*	
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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 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 in 1	K 147	K-147: The Maintenance Director or designee will remove the second surge protector that was plugged into the initial surge protector. The Maintenance Director or designee will conduct a facility-wide audit to confirm that all surge protectors are used correctly by not having a second surge protector plugged into the initial protector.	

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K 147	Continued From page 5 of 5 smoke compartments. The findings were: Observation on 7/7/09 at 8:48 AM revealed a surge protector was plugged into an electrical outlet in the kitchen. A second surge protector and a lamp and mixer were noted to be plugged into this device. Five appliances (a radio, a fan, two mixers, and a microwave oven) were plugged into the second surge protector. Interview with the maintenance manager at the time confirmed the above observation.	K 147	*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 Maintenance Director will incorporate into the preventative maintenance schedule the inspection of all surge protectors to ensure they are being used correctly. Random audits will be preformed monthly for 3 months by the Maintenance Director or designee to confirm that all surge protectors are being used correctly. Results of the random audits will be presented to the QA&A committee monthly for 3 months Date of compliance is August 10, 2009.	