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

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	08/13/2009

RECEIVED Wyoming Dept of Health OCT 07 2009 Office of Healthcare Licensing and Surveys

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYOMING HEALTHCARE A	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 K7 SURVEY UNDER: 2000 EXISTING K8 SNF THIS FACILITY WAS SURVEYED USING THE 2000 EXISTING SECTION OF THE LIFE SAFETY CODE (LSC) IN ACCORDANCE WITH 42 CFR 483.70(a) OF THE FEDERAL REGISTER. THE BUILDING IS A SINGLE STORY TYPE V (111) STRUCTURE WITH A BASEMENT. THE FACILITY WAS CURRENTLY UNDERGOING RENOVATION OF THE HVAC SYSTEM THROUGHOUT. THE FACILITY WAS FULLY SPRINKLERED WITH A WET SYSTEM THROUGHOUT WITH THE EXCEPTION OF THE OUTSIDE OVERHANGS IN EXCESS OF FOUR FEET THAT WERE PROTECTED BY AN ANTI-FREEZE BRANCH OF THE AUTOMATIC SPRINKLER SYSTEM. THE FACILITY HAD A BED CAPACITY OF 62 BEDS. THE DEFICIENCIES WERE AS FOLLOWS:	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 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 029 SS=D	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	K 029	K-029: The Maintenance Director or designee will repair the oxygen storage closet next to resident room 46, and install a self-closure for the tub room doors across from room 50. The Maintenance Director or designee will conduct a facility-wide audit to confirm that all oxygen storage closets doors and doors that need self-closures latch properly. The Maintenance Director will incorporate into the preventative maintenance schedule the inspection of all oxygen closet doors and doors that need self-closures to ensure that the doors latch properly. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that all oxygen closet doors and doors that need self-closures latch properly. Date of compliance is September 13, 2009.	x 9/13/09 walk

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x [signature] TITLE: x Executive Director (X6) DATE: x 9/9/09

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.

CMS rec'd 9/11/09 via U.P.S. Revised POC accepted 9/21/09

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

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 _____	08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYOMING HEALTHCARE A	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 029	Continued From page 1 This Standard is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to maintain automatic door closure and latching of doors for hazardous areas. The findings include: A tour of the facility was conducted on 8/13/09 with the housekeeping supervisor. The following issues were observed during the tour: 1. Observation was made of the oxygen storage closet next to resident room 46.The door to the closet would not latch upon closing the door. Several attempts were made to exercise the door and latch, but the door would not latch into the door frame. This was confirmed by the housekeeping supervisor at the time of the observation. 2. Observation was made of the tub room located across from resident room 50. The room was being remodeled and was being used for storage. It contained in excess of 40 large combustible cardboard boxes. Most of these boxes contained disposable adult diapers. This was confirmed by the housekeeping supervisor at the time of the observation. The room had two doors that exited to an open corridor area. Neither door was protected by a self-closing device as required for protection of a hazardous area.	K 029	K-056: The Maintenance Director or designee will install a sprinkler in the area of the porch off the kitchen. The Maintenance Director or designee will conduct a facility-wide audit to confirm that all areas that need sprinklers have a working sprinkler. The Maintenance Director will incorporate into the preventative maintenance schedule the inspections of all areas are protected be the automatic sprinkler system. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that all areas are protected be the automatic sprinkler system. Date of compliance is September 13, 2009.	9/13/09 Wah
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056		

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

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 _____	08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYOMING HEALTHCARE A	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 056	Continued From page 2 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to maintain a complete sprinkler system. The findings include: 1.A tour of the facility was conducted on 8/13/09 with the facility housekeeping supervisor. Observation was made of the kitchen and back entrance to the service and delivery area just above the basement exit. The area of the enclosed porch was not protected by the automatic sprinkler system. Although there were sprinklers that provided coverage in the main kitchen area, the area of the porch was not fully protected and the lintel of the door between the porch and the main kitchen area would cause the heat of a fire in the porch area to be collected in the unprotected area and delay the activation of any sprinklers in the main kitchen area.	K 056	K-147. The Maintenance Director or designee will remove power bars, extension cords and repair any electrical cords that are routed incorrectly. The Maintenance Director or designee will conduct a facility wide audit to confirm that all power bars, extension cords and electrical cords are used properly. The Maintenance Director will incorporate into the preventative maintenance schedule the inspection of all power bars, extension cords and electrical cords for proper use. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that all power bars, extension cords and electrical cords are used properly. Date of compliance is September 13, 2009.	9/13/09 wah
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:	K 147		

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

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 _____	08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYOMING HEALTHCARE A	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 147	Continued From page 3 Based on observation and staff interview it was determined that the facility failed to maintain electrical wiring and equipment in accordance with NFPA 70. The findings include: 1.During a tour of the facility on 8/13/09 with the housekeeping supervisor the following concerns were identified regarding electrical wiring: A.Observation was made of the employee lounge. A power bar was being utilized for operation of a window refrigerated air conditioner and a refrigerated water cooler. This was confirmed by the housekeeping supervisor at the time of the observation. B. Observation was made of the freezer located in the main dining room. The electrical cord from the freeze had been routed through a hole in the wall into a closet where the ice machine was located and plugged into an electrical receptacle in the closet. The electrical cord for the freezer was not rated for in wall use. C. The electrical cord for the refrigerated air conditioner in the kitchen was routed to the outside of the building. It was plugged into a power bar that was being utilized as an extension cord and extended over six feet, was attached to the outside wall of the kitchen porch and plugged into an electrical receptacle located by the kitchen porch door	K 147		