STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 a fully sprinklered, single story building of Type V (111) construction with plan approval in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 107 residents.	K 000	Preparation and execution of this response and plan of correction does not constitute an 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 solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the state operations manual.	
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 arrange exit access so that exits are readily accessible at all times in 5 of 7 smoke compartments. The findings were: 1. Observation on 04/05/16 at 9:52 AM of the Director of Nursing office revealed the door required tight pinching, and more than one releasing operation to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one releasing operation. 2. Observation on 04/05/16 at 10:16 AM of the Activities office revealed the door required tight pinching, and more than one releasing operation	K 038	K038 A. Locks in the Director of Nursing office, the activities office, the employee exit door and the kitchen bathroom door replaced on 4/20/16 with single action release locks. B. A 100% audit of all doors was completed with the state survey team on 4/5/16. C. An education with the Director of Maintenance was completed on 4/11/16 regarding the need for single action locks within the facility. Audits of door locks will	5/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/27/16

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.

RECEIVED
APR 28 2016
Wyoming Department of Health
Healthcare Licensing

POC Accepted VIA Phone Call with Administrator Mathew Guerthman on 5/11/16 @ 10:23AM

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K 038	Continued From page 1 to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one releasing operation. 3. Observation on 04/05/16 at 10:30 AM revealed the door to the nurses station to the secured unit was double locked and required more than on releasing operation to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door was double locked. 4. Observation on 04/05/16 at 10:48 AM revealed the employee exit door was locked, and required the use of a key pad and pin to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door was locked and required the use of the key pad. 5. Observation on 04/05/16 at 11:06 AM of the kitchen bathroom revealed the door required tight pinching, and more than one releasing operation to make the door operable. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one releasing operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	be conducted at the rate of five rooms per week for two weeks and then five rooms per month for the following three months. D. The maintenance director or designee will summarize and report his findings to the P.I committee monthly. The P. I. committee is the quality assurance group within the facility that is composed of the Executive Director, Director of Nursing, Medical Director and other department managers. The group meets monthly to review clinical audits, customer service issues and other regulatory compliance issues. If a problematic trend(s) is identified the committee develops, or causes the development, of an action plan designed to mitigate the chance of recurrence. The results of the action plan are reviewed in subsequent months for effectiveness and modified as necessary.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1	K 047	K047 A. The exit signs above the therapy room door and the double doors to the secure unit were removed by the facility's director of maintenance on 4/20/16.	5/1/16

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K 047	Continued From page 2 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure doors that are neither an exit nor a way of exit access were properly labeled in 2 of 7 smoke compartments. The findings were: 1. Observation of the Physical Therapy room on 04/05/16 at 9:40 AM revealed a door leading to the outside of the building. The door was locked, and equipped with a key pad requiring a code to unlock the door. Further observation revealed the door was labeled as an exit. Interview with the Facility Maintenance Manager at the time of the observation confirmed the door was locked and revealed that the doors were not a required exit. 2. Observation of the double doors leading to the secured unit on 04/05/16 at 10:20 AM revealed the doors were locked, and equipped with a key pad requiring a code to unlock the doors. Further observation revealed the doors were labeled exit. Interview with the Facility Maintenance Manager at the time of the observation confirmed the doors were locked and revealed that the doors were not a required exit. Ref: 2000 NFPA 101, Sections 19.2.10.1 and 7.10.8.1	K 047	B. A 100% audit of all exit signs was completed on 4/5/16 and found all other signs in compliance. C. An education with the Maintenance Director was completed on 4/11/16 regarding the requirements of exit doors. A 100% audit of all exit signs will be completed monthly by the maintenance director of designee for the next three months. D. The maintenance director or designee will summarize and report his findings to the P.I committee monthly.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 050	K050 A. The facility performed the last fire drill on 3/29/116. B. Surveyor completed a 100% audit for the previous year and the	4/20/16

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K 050	Continued From page 3 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to complete fire drills at least quarterly on each shift in 2 of 4 quarters. The findings were: Document review on 04/05/16 from 11:40 AM to 12:10 PM of fire drills revealed drills were not completed on the night shift for the month of May 2015 and August 2015. At the time of the document review the Facility Maintenance Manager confirmed drills were not completed during these months. Ref: 2000 NFPA 101, Section 19.7.1.2	K 050	two night shift drills were the only two undocumented. C. TELS system tracks and audits required drills. Documentation of these drills will be printed and tracked in a separate binder as well. D. All audits and drills will be summarized, reported and reviewed by the P.I. Committee for the next three months.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10 in 1 of 7 smoke compartments. The findings were:	K 064	K064 A. The fire extinguisher in the secure unit was lowered to meet standard. B. Surveyor complete a 100% audit of the facilities fire extinguishers, and no others were found deficient. C. The maintenance director will inspect all fire extinguishers on a monthly basis to ensure they meet standard. D. Any fire extinguishers out of	4/20/16

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K 064	Continued From page 4 Observation of the fire extinguisher in the secured unit nurses station on 04/05/16 at 10:30 AM revealed the extinguisher was mounted on the wall with the top of the fire extinguisher approximately 69 inches from the floor. At the time of the observation the Facility Maintenance Manger acknowledge the height of the extinguisher. Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1998 NFPA 10, Section 1-6.10	K 064	compliance will be corrected upon discovery and reported to the P.I. committee. K076 A. All combustible materials were moved from the oxygen storage room. B. The Oxygen room referenced within the 2567 is the only oxygen room in the facility. C. The oxygen room will be inspected on a daily basis for two weeks by the facility's maintenance director or designee and then weekly for the next two months to ensure combustible materials are not being stored. D. An education of all staff was conducted on 4/27/16 E. All audits will be summarized, reported and reviewed by the P.I. Committee for the next three months.	5/1/16
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medical gas storage areas are protected in accordance with NFPA 99 in 1 of 1 storage locations. The findings were: Observation of the Oxygen Storage Room on 04/05/16 at 10:55 AM revealed combustible materials located within the space to include 4 oxygen concentrators. At the time of the observation the Facility Maintenance Manager acknowledged combustible materials were located inside the storage location.	K 076		

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K 076	Continued From page 5 Ref: 2000 NFPA 101, Section 19.3.2.4 1999 NFPA 99, Section 4-3.1.1.2	K 076		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per the requirements of NFPA 101 in 1 of 5 smoke barriers. The findings were: Observation on 04/05/16 at 11:35 AM of the smoke barrier adjacent to rooms #101 and #107 revealed duct work that had been removed resulting in an 8 inch circular penetration through the smoke barrier. At the time of the observation the Facility Maintenance Manager acknowledged the removed duct work and penetration. Ref: 2000 NFPA 101, Sections 19.3.7.3 and 8.3.6.1	K 104	K104 A. The duct in question was re-attached on 4/11/16 B. An audit of all ducts was completed by the maintenance director on 4/20/16 C. Checks of the ductwork within the ceiling will be added to room inspections. Rooms will be inspected at the rate of five rooms per week for two weeks and then five rooms per month for the next two months. D. All audits will be summarized, reported and reviewed by the P.I. Committee for the next three months.	4/20/16
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.	K 144		

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K 144	Continued From page 6 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator per the requirements of NFPA 110. The findings were: Document review on 04/05/16 from 11:40 AM to 12:10 PM of the generator maintenance records revealed the diesel powered generator was exercised monthly under load for 30 minutes at 10 percent of the nameplate rating. Further observation revealed no annual load bank had been performed. Interview with the Facility Maintenance Manager at the time of the document review confirmed that annual load bank had not been performed. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.3 1999 NFPA 110, Sections 6-4.2 and 6-4.2.2	K 144	K144 A. A load bank test was scheduled with our service technicians to be completed in June 2016. B. A 100% audit was completed by the surveyor on 4/5/16. C. TELS system tracks and audits required tests. Documentation of these tests will be printed and tracked in a separate binder as well. D. All tests will be summarized, reported and reviewed by the P.I. Committee for the next three months.	4/20/16