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

PRINTED: 08/26/2009
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
	535017	A. BUILDING _____ B. WING LSC APARTMENT BUILDING	08/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Apartment Buildings, of the National Fire Protection Association (NFPA). The facility was a non-sprinkled single story building of Type V (111) construction built in 1978. The building is separated from Sublette Center by a 2-hour fire rated wall, residents from Sublette Center use the dinning room on a daily basis. The building was equipped with a zoned fire alarm system.	K 000	POC accepted w/ Heather McVee, MHA, on 9/30/09.	
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 2 sets of fire barrier doors were smoke resistant. The findings were: Observation on 8/11/09 at 10:55 AM showed the fire barrier doors near the laundry did not fully latch into the frame, with three attempts. At the time of observation the maintenance director reported all barrier doors were inspected monthly.	K 011	011 The facility will ensure that communicating openings occur only in corridors and are protected by approved self-closing fire doors. The facility will also ensure that these doors are smoke resistant and fully latch into the frame. 1. The Maintenance Director (hereafter referred to as MD) adjusted the fire barrier door near the laundry such that the door fully latches into the frame 2. Facility staff shall immediately report malfunctioning latches on self closing fire doors to the MD. In addition, the MD shall conduct monthly inspections of all self-closing doors, and report at the quarterly QAA meeting with appropriate follow up.	8/11/2009

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

Administrator 9-15-09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that thor safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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	535017	A. BUILDING 01 - MAIN BUILDING B. WING	08/11/2009

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this 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 of Type V (111) construction built in 1978 and 1983. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility has a capacity of 50 certified Medicare and Medicaid beds.	K 000	POC ACCEPTED W/ HEATHER MCVEY, NHA ON 9/29/09. M.D. (MAINTENANCE DIRECTOR)	
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 ceilings were smoke resistant in 2 of 5 smoke compartments. The findings were: 1. Observation on 8/11/09 at 9:40 AM showed the drier vent chase in the laundry room had three unsealed penetrations. The largest hole was 18 inches square. At the time of observation the maintenance director reported the holes had been cut two weeks earlier to access vent pipes. He further stated the holes should have been sealed after the repairs had been made.	K 012	012 The facility will ensure that ceilings are smoke resistant. 9/27/2009 1. MD will seal the penetrations in the laundry room by replacing the sheet rock in laundry dryer chase. 2. MD sealed the penetration in the MDS office ceiling by caulking around the hole. 9/3/2009 The MD shall monitor outside contractors to ensure that all holes or penetrations made in walls and or ceilings are filled prior to signing off on the project. In addition, the MD shall conduct monthly inspections of all ceilings and report at the quarterly QAA meeting with appropriate follow up.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather McVey	Administrator	9-15-09

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.

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K 012	Continued From page 1 2. Observation on 8/11/09 at 1:42 PM showed the MDS (Minimum Data Set) office had computer cables running through an unsealed ceiling penetration. The penetration was 1/2-inch in diameter. At the time of observation the maintenance director reported offices were not routinely inspected during preventative maintenance rounds.	K 012		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor walls were smoke resistant in 1 of 5 smoke compartments. The findings were: Observation on 8/11/09 at 10:14 AM showed the corridor ceiling near the front lobby had a 1/2-inch	K 017	017 The facility will ensure that corridor walls are smoke resistant. 1. The MD will seal the penetration in the corridor ceiling near the front lobby by caulking around the cable penetration. The MD shall inspect areas around cable penetrations and fill all open areas. MD will report at the quarterly QAA meeting with appropriate follow up.	9/27/2009

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9/25/09

(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 017	Continued From page 2 unsealed cable penetration. The cable from a video camera ran through the hole into the attic. At the time of observation the maintenance director reported the camera and hole had been installed more than one year ago.	K 017		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 3 of 4 smoke barrier walls were smoke resistant. The findings were: 1. Observation on 8/11/09 at 9:36 AM showed the laundry smoke barrier wall above the supply room had three unsealed pipe penetrations and two unsealed wall penetrations. The largest wall penetration was an open space of 4 inches by 5 inches. At the time of observation the maintenance director reported smoke barrier walls were not routinely inspected. 2. Observation on 8/11/09 at 1:56 PM showed the north smoke barrier wall was missing a 2 foot by 4 foot section of wall. At the time of observation	K 025	025 The facility will ensure that smoke barrier walls are smoke resistant. 1. The MD will seal the three pipe penetrations and two wall penetration s in the laundry smoke barrier. 2. The MD will replace the missing sheetrock on the north smoke barrier wall. 3. The MD will replace the missing sheetrock on the west smoke barrier door. The MD shall monitor outside contractors to ensure that all holes or penetrations made in walls and or ceilings are filled prior to signing off on the project. In addition, the MD shall conduct monthly inspections of all barrier walls and report at the quarterly QAA meeting with appropriate follow up.	9/27/2009

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9/30/09

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K 025	Continued From page 3 the maintenance director reported he was unaware when the section was removed. 3. Observation on 8/11/09 at 2:10 PM showed the west smoke barrier wall was missing a 2 foot square section of wall.	K 025		
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 from use areas in 1 of 5 smoke compartments. The findings were: 1. Observation on 8/11/09 at 9:48 AM showed the ceiling in the main electrical room had a large crack in the ceiling with a 1/2 inch gap between the ceiling material. At the time of observation the maintenance director reported the damage occurred during repairs to the attic space. He further reported the project has been completed in August 2008. 2. Observation on 8/11/09 at 10:24 AM showed	K 029	029 The facility will ensure that hazardous areas are separated from use areas. 1. The MD will repair the crack in the ceiling of the main electrical room with new sheetrock.	9/27/2009
			2. The MD will seal the wall penetrations in the boiler room with fire rated caulking.	9/27/2009
			3. The MD removed the rubber stop preventing the kitchen dry storeroom door from closing and educated staff not to prop the door open.	8/12/2009
			4. MD will install an automatic door closer in the kitchen toilet room.	9/27/2009
			5. The MD will seal penetrations in the kitchen janitors closet with fire-rated caulking.	9/27/2009
			The MD shall monitor outside contractors to ensure that all holes or penetrations made in walls and or ceilings are filled prior to signing off on the project. In addition, the MD shall conduct monthly inspections of all barrier walls and report at the quarterly QAA meeting with appropriate follow up.	

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K 029	Continued From page 4 the kitchen boiler room had two unsealed wall penetrations. The penetrations were 1/2 inch in diameter. At the time of observation the maintenance director reported the area was not routinely inspected to ensure smoke resistance. He was not aware of when the holes were made in the wall. 3. Observation on 8/11/09 at 10:28 AM showed the kitchen dry storeroom door was equipped with an automatic closing device. The closure was unable to latch the door into the frame because it was wedged open with a rubber stop. At the time of observation the maintenance director reported he was aware doors to hazardous areas should not be propped open. He further reported all staff members had been in-serviced not to prop open doors. 4. Observation on 8/11/09 at 10:40 AM showed paper products were being stored in the kitchen toilet room. The room was 64 square feet and the paper products filled the eight foot tall shelf. The door to the room was not equipped with an automatic closing device. At the time of observation the maintenance director reported he was unaware rooms greater than 50 square feet that stored combustible material required automatic closures on the doors. 5. Observation on 8/11/09 at 10:42 AM showed the kitchen janitors' closet had two wall penetrations that were each 1/2-inch in diameter. There was also a 2-inch unsealed pipe penetration with a 1-1/2-inch pipe running through it.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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9/30/09

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K 038	Continued From page 5 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 exit doors swung with the path of egress in 1 of 5 smoke compartments. The findings were: Observation on 8/11/09 at 1:30 PM showed the double courtyard gate doors outside of the main dining room did not swing with the direction of travel in the path of egress. At the time of observation the maintenance director reported the doors were originally designed to swing with the direction of travel, but a vertical post where the hinges attached had been damaged and the the gates were moved to the other side of the post. He further reported the doors had been in this configuration for more than two years. He also reported that he was not aware exit doors were required to swing with the direction of travel.	K 038	038 The facility shall ensure that exit accesses are readily accessible at all times. 1. The MD will repair the double courtyard gates outside the main dining room such that they swing with the direction of travel in the path of egress. The MD shall regularly inspect all exit access and report at the quarterly QAA meeting with appropriate follow up.	9/27/2009
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1¼ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to test the emergency battery lights during 1 of the past 12 months. The findings were:	K 046	046 The facility shall ensure that emergency lighting of at least 1.5 hour duration is provided and operable. 1. The MD will conduct monthly tests of the emergency lighting system. The MD shall document tests of the emergency lighting system and report at the quarterly QAA meeting with appropriate follow up.	9/27/09

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K 046	Continued From page 6 Review of the emergency battery light testing records showed they had not been tested during the month of July 2009. On 8/11/09 at 3:15 PM the maintenance director confirmed the he was aware the lights were to be tested monthly.	K 046		
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, observation and staff interview the facility failed to ensure manual fire alarm boxes were unobstructed, failed to ensure the fire alarm system was inspected annually, failed to test all fire alarm devices, and failed to ensure the central station certification was posted. The findings were: 1. Observation on 8/11/09 at 1:51 PM showed the manual fire alarm box in the sun room was obstructed by three plants. At the time of the observation the maintenance director reported he was aware pull stations were required to be unobstructed. He further stated pull stations were inspected weekly.	K 052	052 The facility will comply with all inspection, maintenance and testing requirements per the NFPA for the fire alarm system. 1. The MD removed the items blocking the manual fire alarm in the sunroom 2. The facility shall conform to the 12 month interval between fire alarm tests, and will have inspections completed on or before the due date. 3. The MD posted the UL listing certificate for the central station within 36 inches of the main fire alarm panel. The MD shall inspect and document compliance with fire alarm inspection, maintenance, and testing requirements on a monthly basis and report at the quarterly QAA meeting with appropriate follow up.	8/11/2009 8/31/2009

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K 052	Continued From page 7 2. Review of the fire alarm testing records showed the last inspection occurred on 2/24/09. Further review showed the prior inspection had occurred in November 2007, which exceeded the required 12-month interval. The last inspection also showed that only 23 of the 27 alarm notification devices were tested. On 8/11/09 at 3:15 PM the maintenance director confirmed the aforementioned testing had been missed. 3. Review of the fire alarm testing records showed the system was monitored by a central station. The facility did not have the certification for the central station. On 8/11/09 at 3:32 PM the maintenance director reported he was unaware the central station was required a certification or and that the certification was required to be posted within 36-inches of the main fire alarm panel.	K 052		
K 056 SS=E	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 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	K 056	The facility shall install an automatic sprinkler system in accordance with NFPA 13 to provide complete coverage for all portions of the building, maintain it in accordance with NFPA 25, and ensure it is fully supervised with a reliable, adequate water supply and equipped with water flow and tamper switches which are electronically connected to the fire alarm system. 1. The facility will install sprinklers in the main electrical room upon state approval of the installation plan. 2. The MD removed the wood frame shelter covering the condenser units for the kitchen freezer.	9/3/2009

This STANDARD is not met as evidenced by:

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K 056	Continued From page 8 Based on observation and staff interview the facility failed to ensure 2 of 5 smoke compartments had complete sprinkler coverage. The findings were: 1. Observation on 8/11/09 at 10:02 AM showed sprinklers had not been installed in the main electrical room. At the time of observation the maintenance director reported he was not aware the room did not have sprinkler coverage. He further reported the annual sprinkler head inspection was conducted by an outside contractor. The last sprinkler reported did not indicate the facility was lacking sprinkler coverage. 2. Observation on 8/11/09 at 10:34 AM showed the condenser unit for the kitchen freezers was covered by a wood frame shelter. The shelter was 55 inches deep and 96 inches wide and attached to the nursing home. A sprinkler head was not installed under the shelter. At the time of observation the maintenance director reported he was not aware that wood frame structures deeper than 48 inches were required to have sprinkler coverage. He further reported the structure had been in place for more than a year. 3. Observation on 8/11/09 at 11:59 AM showed the corridor near the television room did not have complete sprinkler coverage. The corridor sprinkler located south of the north smoke barrier wall was 15 feet from the barrier. At the time of observation the maintenance director was not aware ordinary sprinklers had a maximum radius coverage of 7 1/2 feet.	K 056	3. The facility will install sprinklers to cover the corridor near the television room upon state approval of the installation plan. The MD will submit bids for installation of sprinkler heads to cover the aforementioned areas and submit plans to the state for approval. The MD will oversee the installation and initiate monthly inspections of the sprinkler system to document conformance with applicable NFPA regulations. The MD will report these outcomes at the quarterly QAA meeting with appropriate follow up. On September 25, 2009, the facility submitted a request for waiver of compliance until February 15th 2010 in order to install sprinkler systems in the main electrical room (1) and the corridor near the television room (3). The facility shall submit plans for this project to the State by September 30, 2009. Allowing 3 months for plan approval, the installation shall commence January 30, 2010 with a completion date of February 15, 2010	~~2/15/2010~~ 9/24/09
K 062	NFPA 101 LIFE SAFETY CODE STANDARD NS-E Required automatic sprinkler systems are	K 062		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

9/30/09

(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 062	Continued From page 9 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 every sprinkler type had two spare heads, failed to ensure sprinklers were not covered with foreign material, failed to ensure escutcheons rings were smoke resistant in 2 of 5 smoke compartments, and failed to ensure sprinkler devices had been tested during 1 of the past 4 quarters. The findings were: 1. Observation on 8/11/09 at 10:05 AM showed the facility did not have the required two spare sprinkler heads to replace the heads in the kitchen boiler room and the clothing drier closets in the laundry. The facility did not have a 212 degree upright or pendent sprinkler head respectively. At the time of observation the maintenance director reported the spare sprinkler heads was inspected by an outside contractor. He further reported the contractor had not indicated the facility was lacking any spare heads. 2. Observation on 8/11/09 at 11:02 AM showed the sprinkler head in the closet of the bookkeeping office was covered with dry wall texture. 3. Observation on 8/11/09 between 11 AM and 12 PM showed the closet sprinkler in resident room #110 had a 2-inch gap between the escutcheon and the ceiling. Further review showed the sprinkler in the corridor near the nurses' station	K 062	062 The facility will ensure that the sprinkler system is continuously maintained in a reliable operating condition and is inspected and tested periodically. 1. The MD will acquire two spare sprinkler heads to replace the heads in the kitchen boiler room and clothing dryer closet 2. The MD will replace the sprinkler head in the bookkeeping office which was covered with dry wall texture. 3. MD repaired gaps between the escutcheons and ceiling in resident room #110 and in the corridor near the nurses' station. The MD shall inspect the sprinkler system on a monthly basis and report at the quarterly QAA meeting with appropriate follow up.	9/27/2009 9/27/2009 9/2/2009

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

PRINTED: 08/26/2009
FORM APPROVED
OMB NO. 0938-0391

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K 062	Continued From page 10 had a 1/2-inch gap between the escutcheon and the ceiling.	K 062		
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 facility failed to ensure fabric wall covering was flame retardant in 1 of 5 smoke compartments. The findings were: Observation on 8/11/09 at 4:07 PM showed a homemade cotton blanket was hung on the wall in resident room #1 from floor to ceiling. At the time of observation the maintenance director reported the blanket was not flame retardant. He further reported that the blanket had not been	K 074	074 The facility shall ensure that all furnishings and decorations are in accordance with NFPA criteria and standards. 1. The MD will inform the family of the resident in room #1 that the blanket hung on the wall must either be removed or treated with a flame retardant spray. The nursing staff and the MD will inspect resident rooms on a regular basis to ensure that furnishings and decorations are flame retardant. The MD will report at the quarterly QAA meeting with appropriate follow up.	9/27/2009

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PRINTED: 08/26/200
FORM APPROVEI
OMB NO. 0938-039

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	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 074	Continued From page 11 treated with a flame retardant spray.	K 074		
K 141 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview the facility failed to ensure rooms with oxygen in use were posted with signage prohibiting smoking in 1 of 5 smoke compartments. The findings were: Observation on 8/11/09 between 11 AM and 11:30 AM showed resident room #101 and #104 had oxygen in use and the corridor doors were not posted with "No Smoking" signs. All other resident rooms with oxygen in use were posted with No Smoking signs. Review of the facility's tobacco use policy stated "Oxygen signs marked on front doors, and exits." The policy did not address were no smoking signs would be posted. At 4:30 PM the administrator confirmed the policy did not address the posting of signs.	K 141	141 9/27/2009 The facility will ensure that rooms with oxygen in use are posted with signage prohibiting smoking. 1. The Administrator shall design a policy for the posting of "No Smoking" signs which will be applied in a consistent manner throughout the facility. 2. The DON will instruct nursing staff on the proper placement of oxygen is use signs. The Administrator and DON will monitor and document proper placement of oxygen in use and no smoking signage and will report at the quarterly QAA meeting with appropriate follow up.	
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 electrical receptacles in wet locations were GFCI (Ground Fault Circuit Interrupter) protected, failed to ensure electrical	K 147		

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K 147	Continued From page 12 equipment had adequate work space, and failed to ensure temporary wiring did not replace permanent fixed wiring. The findings were: 1. Observation on 8/11/09 between 10 AM and 12 PM showed the electrical receptacles near the wheelchair washer, behind the clothes washer, in the medication room, and in resident rooms #5, #9 and #10 were all located within 6 feet of a water source and not protected with a GFCI receptacle. At 10:09 AM the maintenance director reported he was unaware existing receptacles near water sources required GFCI protection. 2. Observation on 8/11/09 at 11:10 AM showed the two electrical panels in the south linen closet were obstructed by a linen cart stored directly in front of them. At the time of observation the maintenance director reported he was aware the panels could not be obstructed. 3. Observation on 8/11/09 at 11:21 AM showed the television in resident room #106 was plugged into an extension cord. At the time of observation the maintenance director reported he was aware extension cords were prohibited. He further reported the electrical wiring in resident rooms was inspected weekly during environmental rounds. 4. Observation on 8/11/09 at 11:46 AM showed the receptacle behind bed "A" in resident room #210 was cracked between the blade ports.	K 147, 147	The facility shall ensure that electrical receptacles in wet locations are GFCI protected, equipment has adequate work space, and that temporary wiring will not replace permanent fixed wiring. 1. The MD will replace existing electrical outlets near the wheelchair washer, behind the clothes washer, in the medication room, and resident rooms #5, #9, and #10 with a GFCI receptacle. 2. The linen cart was moved away from the two electrical panels in the south linen closet, and the Environmental Services Director posted signs informing staff not to place linen carts within 2 feet of electrical panels. 3. The MD removed the extension cord and replaced it with a surge protector. The Environmental Services Director and the MD informed the family that extension cords are not allowed in the resident's room. 4. The MD replaced the broken outlet. The MD shall conduct monthly inspections of the electrical system, including the status of outlets and wiring systems and report at the quarterly QAA meeting with appropriate follow up.	9/27/2009 8/11/2009 8/11/2009 8/11/2009