STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEA B. WING _____	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

7/5/11 John W. Brun

(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 Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled three story building with a basement of Type II (222) construction with plan approval in 1972. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 123 residents.	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 025 SS=E	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 2 of 8 smoke barrier walls were smoke resistant. The findings were:	K 025	K-025: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee sealed the ½ inch holes in the Transitional Care Unit and the Laramie Peak Hall. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that smoke barrier holes have been sealed. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their ~~routine~~ rounds the inspection of smoke barrier walls to confirm that penetration holes do not exist. monthly JWB	

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

Dan Stackis | Executive Director | 06-20-11

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.

P.o.C. modified & accepted with Dan Stackis, E.D., on 7/5/11 John W. Brun

RECEIVED
Wyoming Dept of Health
JUN 20 2011
Office of Healthcare Licensing and Surveys

Hand delivered
Susan

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7/5/11 John W. Benson

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K 025	Continued From page 1 1. Observation of the smoke barrier wall to the Transitional Care Unit (TCU) on 5/24/11 at 2:35 PM showed an unsealed 1/2-inch hole, through which a red fire alarm cable had run. At the time of the observation, the maintenance director stated that he did not know why the penetration was not identified during the last quarterly inspection. 2. Observation of the smoke barrier wall to the Laramie Peak Hall on 5/24/11 at 2:50 PM showed an unsealed 1/2-inch hole, through which a red cable had run. At the time of the observation, the maintenance director stated that he did not know why the penetration was not identified during the last quarterly inspection.	K 025	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly times 3 months by the Maintenance Director/Designee to confirm that penetration holes do not exist on the smoke barrier walls. The Maintenance Director/Designee will report any concerns related to penetration holes in smoke barrier walls to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	Date of compliance is July 10, 2011. K-051: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee moved the smoke detectors located in the beauty shop, 1st floor activities room, 2nd floor activities room, 3rd floor north shower room, and the 3rd floor south shower room at least 3 feet away from direct air flow. The Maintenance Director/Designee re-synchronized the three strobe lights in the TCU north hall so that they flash simultaneously.	

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure smoke detectors had proper spacing in 4 of 12 smoke compartments and failed to ensure notification devices had proper synchronization in 1 of 12 smoke compartments. NFPA 72, 1999, 2002, 2007 edition: Section 5.7.4.1* In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Appendix A: 5.7.4.1 Detectors should not be located in a direct airflow or closer than 1 m (3 ft) from an air supply diffuser or return air opening ... The findings were: 1. Observation on 5/24/11 between 10:05 AM and 2:20 PM revealed smoke detectors were located less than 36 inches from ventilation diffusers in the following locations: a. Beauty shop - 16 inches b. 1st floor activities room - 12 inches c. 2nd floor activities room - 18 inches d. 3rd floor north shower room - 8 inches e. 3rd floor south shower room - 8 inches At the time of the observations, the maintenance director reported that he was unaware of the spacing requirement. 2. Observation of the TCU north hall on 5/24/11 at 3:23 PM showed three strobe lights located in	K 051	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that smoke detectors are located 3 feet away from direct air flow. Those identified as not in compliance will be moved at least 3 feet away from direct airflow. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all strobe lights flash simultaneously. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their routine rounds the inspection of the location of smoke detectors to confirm that all smoke detectors are located at least 3 feet away from direct air flow. The Maintenance Director/Designee will incorporate into their ~~routine~~ monthly rounds the inspection of strobe lights to ensure that they flash simultaneously.	

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure smoke detectors had proper spacing in 4 of 12 smoke compartments and failed to ensure notification devices had proper synchronization in 1 of 12 smoke compartments. NFPA 72, 1999, 2002, 2007 edition: Section 5.7.4.1* In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Appendix A: 5.7.4.1 Detectors should not be located in a direct airflow or closer than 1 m (3 ft) from an air supply diffuser or return air opening ... The findings were: 1. Observation on 5/24/11 between 10:05 AM and 2:20 PM revealed smoke detectors were located less than 36 inches from ventilation diffusers in the following locations: a. Beauty shop - 16 inches b. 1st floor activities room - 12 inches c. 2nd floor activities room - 18 inches d. 3rd floor north shower room - 8 inches e. 3rd floor south shower room - 8 inches At the time of the observations, the maintenance director reported that he was unaware of the spacing requirement. 2. Observation of the TCU north hall on 5/24/11 at 3:23 PM showed three strobe lights located in	K 051	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will confirm that all future smoke detectors are located no closer than 3 feet from direct air flow. The Maintenance Director/Designee will confirm that all strobe lights flash simultaneously. Random audits will be performed by the Maintenance Director/Designee to confirm that smoke detectors are not located closer than 3 feet from direct air flow and that strobe lights flash simultaneously. The Maintenance Director/Designee will report any concerns regarding the location of smoke detectors near direct air flow and the synchronization of strobe lights to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	

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K 051	Continued From page 3 the line of sight did not flash simultaneously. At the time of observation, the maintenance director reported that he was unaware of that requirement.	K 051		
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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 12 smoke compartments had complete sprinkler coverage. The findings were: Observation of the sprinkler system in stair tower "B" on 5/24/11 at 11:25 AM showed that no sprinkler head was located at the bottom landing in the stairwell. At the time of observation, the maintenance director stated that he did not know why the missing head had not been identified during the annual sprinkler inspection conducted by the facility staff.	K 056	K-056: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee moved the ~~installed a~~ sprinkler head to cover the ~~at the~~ bottom of the landing area of stair tower "B." JMD **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all stair towers have a sprinkler head at the bottom landing area of the stair tower. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their ~~routine~~ rounds the inspection of all stair towers to confirm that there is a sprinkler head located near the bottom of the landing area. monthly JMD **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly	
K 130	NFPA 101 MISCELLANEOUS	K 130		

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K 130	NFPA 101 MISCELLANEOUS	K 130		

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K 130 SS=E	Continued From page 4 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 the protection of liquefied petroleum gases. NFPA 58 Liquefied Petroleum Gas Code: Section 8.4.2.1 Cylinders at a location open to the public shall be protected by either of the following: ...(2) A lockable ventilated enclosure of metal exterior construction. The findings were: Observation of the exterior covered deck outside the 1st floor main dining hall on 5/24/11 at 11:30 AM showed two 3-gallon propane bottles for a barbecue grill were stored under the canopy. At the time of observation, the maintenance director stated that he was not aware of any protection requirements.	K 130	K-130: Miscellaneous – Other LSC Deficiency not on 2786 **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee moved the propane bottles to a secured and ventilated exterior area. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that liquefied petroleum gases are properly stored in a secured and ventilated exterior area.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the	K 143		

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K 130 SS=E	Continued From page 4 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 the protection of liquefied petroleum gases. NFPA 58 Liquefied Petroleum Gas Code: Section 8.4.2.1 Cylinders at a location open to the public shall be protected by either of the following: ...(2) A lockable ventilated enclosure of metal exterior construction. The findings were: Observation of the exterior covered deck outside the 1st floor main dining hall on 5/24/11 at 11:30 AM showed two 3-gallon propane bottles for a barbecue grill were stored under the canopy. At the time of observation, the maintenance director stated that he was not aware of any protection requirements.	K 130	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their ~~routine~~ rounds the inspection of liquefied petroleum gases to confirm that they are properly stored in a secured and ventilated exterior area. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly times 3 months by the Maintenance Director/Designee to confirm that liquefied petroleum gases are stored properly. The Maintenance Director/Designee will report any concerns regarding the storage of liquefied petroleum gases to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	monthly JWB
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the	K 143		

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K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the	K 143	K-143: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee provided a face shield for the 1st floor oxygen storeroom.	

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7/5/11

(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 143	Continued From page 5 immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to furnish staff with the proper safety equipment for transfilling liquid oxygen containers. Compressed Gas Association, Inc.: CGA P-2.6-2005 Transfilling of Liquid Oxygen Used For Respiration, Chapter 6 " ...NFPA 99C requires ...that personnel use proper safety equipment ...includes safety glasses, goggles or face shield; insulated loose fitting gloves; cuffless trousers; and work shoes or boots ... " The findings were: Observation in the 1st floor liquid oxygen storeroom on 5/24/11 at 11:10 AM showed a protective face shield was not available to wear. At the time of observation, the maintenance director stated that he was unaware of the regulations.	K 143	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/designee will conduct a facility-wide audit to confirm that liquid oxygen storerooms are equipped with face shields. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their ~~routine~~ rounds the inspection of liquid oxygen rooms to confirm that face shields are being provided. monthly JWB **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly times 3 months by the Maintenance Director/Designee to confirm that face shields are being provided in all liquid oxygen storerooms. The Maintenance Director/Designee will report any concerns regarding face shields being provided in liquid oxygen rooms to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	