PRINTED: 12/02/2008
FORM APPROVED
OMB NO. 0938-0391

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
	535051	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction built in 1972. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system.	K 000		
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 all use areas by smoke resistant barriers in one of four smoke compartments. The findings were: Observation on 11/18/08 at 8:55 AM revealed the gap between the corridor door and frame to the	K 029	K029 NFPA 101 The gap between the door frame and the door has been repaired. The gap now is 1/8 inch. The maintenance director has been educated related to the maximum allowed gap for hazardous area corridor. The Administrator, DON and maintenance director will make weekly round of the building. Any areas of non-compliance will be repaired and the reports of these audits will be presented at monthly QA meetings for 3 months and quarterly thereafter. POC ACCEPTED W/ DEE COMMENTS. NPA, ON 12/22/08.	

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

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
Wyoming Dept of Health
DEC 22 2008
Office of Healthcare Licensing and Surveys

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Wyoming Dept of Health
DEC 18 2008
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12/22/08

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K 029	Continued From page 1 main linen room was greater than the allowed 1/8 inch. The gap between the door and frame measured 1/4 inch. Interview with the maintenance director at the time of observation revealed he was unaware of the maximum allowed gap for hazardous area corridor doors.	K 029	K062 NFPA 101 1. The light in the shower room and in laundry folding room been replaced to insure that the lights do not block the sprinkler head. 2. The sprinkler head in the dish room will be replaced. The maintenance director has been educated related to inspection of condition of sprinkler heads. The Administrator, DON and maintenance director will do random rounds to inspect sprinkler heads. Any sprinkler heads that are corroded or broken will be repaired or replaced immediately. The results of these rounds will be presented at the monthly QA meetings for 3 months and quarterly thereafter.	1/15/09
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are 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 observation and staff interview the facility failed to ensure sprinkler heads were not obstructed in three of four smoke compartments. The findings were: 1. Observation on 11/18/08 between 7:30 AM and 10:30 AM revealed the sprinkler heads in the shower room near resident room #44 and in the laundry folding room were obstructed by a fluorescent light. The lights would be likely to block the spray pattern because they were below the level of the sprinklers. 2. Observation on 11/18/08 at 9:40 AM revealed the sprinkler head in the dish room was corroded. Interview with the maintenance director at the time of observation revealed the sprinkler system was only inspected annually. 3. Observation on 11/18/08 at 9:57 AM revealed cups in the kitchen supply closet were stored closer to the ceiling than allowed by the code.	K 062		

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K 062	Continued From page 2 The cups were located 12 inches from the sprinkler head instead of at least 18 inches, as required.	K 062	K 062 Cont 3. The cup storage has been corrected to meet the regulation of nothing higher than 18 inches from the sprinkler heads. The maintenance director has been educated related to space between sprinkler heads and supplies of any kind. The Administrator, DON and the maintenance director will complete weekly rounds to inspect those areas. The results of these rounds will be presented at monthly QA meetings for 3 months and quarterly thereafter.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards 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. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure oxygen cylinders were properly stored in one of four smoke compartments. The findings were: Observation on 11/18/08 at 8:10 AM revealed two E sized oxygen cylinders were not restrained in the D-hall oxygen storeroom. Interview with the maintenance director at the time of observation revealed the oxygen closet was inspected daily by the nursing staff. He was unaware the cylinders were inappropriately stored.	K 076		
K 141 SS=E	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.	K 141		

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K 141	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, staff interview and facility policy the facility failed to ensure areas where oxygen was in use or stored lacked required signage in two of four smoke compartments. The findings were: 1. Observation on 11/18/08 between 7:30 AM and 9 AM revealed resident rooms #10, #34, #35, #36 and the D-hall oxygen storeroom did not have "No Smoking" signs. 2. Interview with the maintenance director on 11/18/08 at 7:58 AM revealed the nursing staff inspected all rooms to ensure they were posted with No Smoking signs if oxygen was in use. 3. Review of the facility's smoking policy documented "Smoking is not allowed around or near any oxygen in use or being stored. Such locations shall be posted with No Smoking signs." Interview with the maintenance director revealed he was aware of the policy, but unaware as to whether or not signage in oxygen storage areas was adequate.	K 141	K 076 LFPA 101 The oxygen bottles are all restrained per federal regulations. All staff be in serviced related to correct oxygen storage, The maintenance director, Administrator and the DON will perform random audits of the oxygen storage room the insure that all bottles are in racks. The results of these audits will be presented at monthly QA meetings and quarterly thereafter.	1/15/09

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