| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A043 | A. BUILDING 01<br>B. WING | 11/17/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PLATTE COUNTY MEMORIAL NURSING HOME | 204 15TH STREET<br>WHEATLAND, WY 82201 |

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| K 000 | INITIAL COMMENTS<br><br>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).<br><br>The facility was a fully sprinkled single story building with a basement of Type V (111) construction built in 1965 and the east wing addition of Type II (111) built in 1978. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and a zoned fire alarm system. The facility had a capacity of 43 certified Medicaid beds. | K 000 | This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding of the deficiencies cited are correctly applied. | |
| K 012<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure walls were smoke resistant in 1 of 4 smoke compartments. The findings were:<br><br>Observation on 11/17/09 at 11:07 AM showed a 16 by 18 inch section of sheetrock was missing from the wall in the administrator's office. The hole exposed a large electrical junction box. At the time of observation the maintenance director stated he was not aware the hole existed. He further stated he was aware walls must be smoke | K 012 | K012<br>a. Policy: Platte County Memorial Nursing Home (PCMNH) will assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.<br>b. Sheetrock in Administrator's office has been replaced.<br>c. Responsible Party: Maintenance Supervisor<br>d. How it will be prevented in future: Any work contracted to outside contractors will be inspected to ensure repair of any damage to the facility.<br>e. Quarterly inspections of all rooms (including the walls) will be done, a log maintained, and reported to the QA Committee quarterly. | 12/9/09 |

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

Administrator 12/22/09

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.

POC ACCEPTED W/ NANCY GLAWESKE, ANHA, ON 12/29/09.

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| K 012 | Continued From page 1<br>resistant. The administrator's office had not been inspected by maintenance staff since the new managing firm took control. | K 012 | K029<br>a. Policy: PCMNH will ensure hazardous areas are separated from use areas. | |
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 4 smoke compartments. The findings were:<br><br>Observation on 11/17/09 at 10:36 AM showed twenty-one cardboard boxes of paper products and disposable briefs were being stored in resident room #121. The corridor door to the room was not equipped with an automatic-closing device. At the time of observation the maintenance director reported he was aware that storerooms required full separation, including a closing device on the door. He further reported the aforementioned items were being stored in the room because the storeroom in the hospital was no longer available since the management change. | K 029 | b. Room #121 has been cleared of cardboard boxes of paper products and disposable briefs.<br><br>c. Responsible Party: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Off-site storage has been acquired.<br><br>e. Quarterly inspections of all rooms will be done, a log maintained, and reported to the QA Committee quarterly. | 12/9/09 |

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| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on record review, observation and staff interview the facility failed to ensure fire drills were held at varying times on 1 of 3 shifts and staff members were not familiar with necessary emergency actions during a drill on 1 of 3 shifts. The findings were:<br><br>1. Review of the fire drill records showed the third shift occurred between 3 PM and 11 PM. Further review documented that the three fire drills conducted in 2009 all occurred between 3:40 PM and 4:19 PM. On 11/17/09 at 12:15 PM the maintenance director reported he was not aware fire drill times were required to occur at varying times throughout a shift.<br><br>2. Observation of a fire drill on 11/17/09 at 1:27 PM showed two carts were left in the corridor in the smoke compartment of fire origin throughout the drill. A registered nurse that participated in the drill stated that she was not aware the corridors were supposed to be cleared during a drill. She further reported that she had worked at the facility for more than two years. The facility's Code Red | K 050 | K050-<br>a. Policy: Fire Safety Drills will be held at varying times on all three shifts. Staff members will be familiar with necessary emergency actions during a drill.<br><br>b. A meeting was held 12/11/09 with the hospital administrator and hospital maintenance manager to ensure future fire drills occur at varying times throughout a shift. The fire alarm system for both the hospital and nursing home is one system. Staff will be educated to clear the corridors per facility policy.<br><br>c. Responsible Party: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Nursing Home Maintenance Director will take over the scheduling of drills and will educate staff on emergency actions during a drill.<br><br>e. Nursing Home Maintenance Supervisor will monitor and keep a log of frequency and times of fire drills and will report to the QA Committee quarterly. Staff actions during a fire drill will be also be monitored | 12/11/09<br><br>12/31/09<br><br>12/31/09 |

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| K 050 | Continued From page 3<br>(Fire) policy documented "...Remove any equipment or furniture from the hallways." | K 050 | | |
| K 062<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure sprinklers were maintained with required spacing in 3 of 4 smoke compartments. The findings were:<br><br>Observation on 11/17/09 between 10 AM and 12 PM showed the sprinkler heads in the bathroom of resident room #114, the east soiled utility room, the computer server room, and two heads in the corridor near the nurses' station were all maintained with less than a 1-inch gap between the sprinkler deflector and the ceiling. At 10:30 AM the maintenance director reported he was aware of the spacing requirement, and the facility was inspected annually to ensure proper spacing. He further reported that several heads had been lowered last year when noted during the re-certification survey. He was not able to explain why the aforementioned heads had not been identified and corrected by maintenance staff. | K 062 | K-062 –<br>a. Policy: Automatic sprinkler systems are maintained in reliable operating condition and are inspected and tested periodically.<br><br>b. Sprinkler heads have been lowered to meet the 1-inch gap requirement between the sprinkler deflector and the ceiling. Sprinklers will be inspected monthly by maintenance to ensure proper clearance.<br><br>c. Responsible Party: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Sprinkler system will be inspected quarterly.<br><br>e. Maintenance Supervisor will monitor and keep a log of cleaning and inspections and will report to the QA Committee quarterly. | 12/9/09 |
| K 074<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 074 | | |

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| K 074 | Continued From page 4<br>provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.<br><br>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<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure window curtains were flame retardant in 1 of 4 smoke compartments. The findings were:<br><br>Observation on 11/17/09 at 10:21 AM showed the Memory Care dining room had two full length window curtains. Further review showed the curtains did not have flame retardant documentation attached to them. At the time of observation the maintenance director reported the facility did not have a flame retardant log to review. He further reported the facility did not spray curtains with a flame retardant solution. | K 074 | K-074 –<br>a. Policy: All drapes, cubicle curtains, mattresses, carpets, etc., used by this facility are flame resistant.<br><br>b. Window curtains in Memory Care dining room have been removed. Any new furniture and curtains will have flame retardant documentation attached to them or flame retardant information documented in a log.<br><br>c. Responsible person: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Maintenance Supervisor will monitor and keep a log of room inspections.<br><br>e. Room inspections will be reported to the QA Committee quarterly. | 12/9/09 |
| K 076<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. | K 076 | | |

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| K 076 | Continued From page 5<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure 1 of 2 oxygen storage locations were adequately separated from combustible materials. The findings were:<br><br>Observation on 11/17/09 at 10:33 AM showed paper products were being stored in cardboard boxes within 5 feet of oxygen cylinders in the oxygen storeroom. The cardboard boxes were located 3 feet from the oxygen cylinders. At the time of observation the maintenance director reported he was not aware of the 5 foot separation requirement. | K 076 | K-076 –<br>a. Policy: Oxygen storage areas will be clear of combustible materials.<br><br>b. Cardboard boxes in oxygen storage room have been removed.<br><br>c. Responsible person: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Signs have been posted reminding staff to keep a 5-foot clearance around the oxygen cylinders in the storeroom.<br><br>e. Room inspections will be reported to the QA Committee quarterly. | 12/9/09<br><br>12/9/09 |
| K 147 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure electrical receptacles in wet locations were protected in 1 of 4 smoke compartments. The findings were: | K 147 | | |

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| K 147 | Continued From page 6<br><br>Observation on 11/17/09 between 9:30 AM and 11 AM showed electrical receptacles in the north soiled utility room, the toilet room near resident room #105 and at the nurses' station were located within 6 feet of sinks. These receptacles were not protected with GFCI (ground fault circuit interrupter) receptacles. At 9:57 AM the maintenance director reported he was unaware receptacles installed within 6 feet of a water source were required to have GFCI protection. Further review of the facility showed all receptacles in residents room located within 6 feet of a water source had GFCI receptacles. | K 147 | K-147<br>a. Policy: Electrical receptacles near water supplies will be protected with ground fault circuit interrupter (GFCI) receptacles.<br><br>b. Electrical receptacles in the north soiled utility room, the toilet room near resident room #105 and at the nurses' station have been replaced with ground fault circuit interrupter (GFCI) receptacles.<br><br>c. Responsible person: Maintenance Supervisor<br><br>d. How it will be prevented in the future: Any receptacle within 6 feet of a water source will be GFCI.<br><br>e. Room inspections will be reported to the QA Committee quarterly. | 12/9/09 |