STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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 single story building with a basement of Type V (111) construction with plan approval in 1964, 1986, and 1996. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The facility had a capacity of 50 certified Medicare and Medicaid beds with a census of 48 residents.	K 000		
K 029 SS=D	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 4 smoke compartments. The findings were:	K 029	The facility will ensure that hazardous areas are separated from use areas in smoke compartments. The shelf paper cleaning napkins will be removed from the Housekeeping closet. A self-closing device will be installed on the door entering the Housekeeping closet. The Maintenance Manager will be responsible for the aforementioned actions. The Safety Chairperson will monitor compliance during the quarterly safety inspections. The results of these inspections will be reported to the Safety Committee via a performance improvement monitor	3/4/11.

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

Administrator 2/16/11

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.

POC ACCEPTED W/ VERY MINOR, NHA, DON 3/09/11

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Wyoming Dept of Health

FEB 22 2011

Office of Healthcare Licensing and Surveys

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AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

3/04/11

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K 029	Continued From page 1 Observation on 1/25/11 at 10:50 AM showed a shelf of paper cleaning napkins were stored in the housekeeping closet. Further observation showed the corridor door was not equipped with a self-closing device. At the time of observation the maintenance manager reported he was aware of the separation requirement, but could not explain why a self-closing device had not been installed on the aforementioned door.	K 029		
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 ensure corridor doors had adequate head room in 1 of 4 smoke compartments. The findings were: Observation of the hospital fire barrier cross corridor double doors on 1/25/11 at 9:46 AM showed one door was equipped with a magnetic lock. Further review showed the bottom of the magnetic locking device was not the required 6 foot 8 inches above the floor. The bottom of the magnetic lock was only 6 foot 5 inches above the floor. At the time of observation, the maintenance director reported he was not aware of the aforementioned requirement.	K 038	The facility will ensure that corridor doors have adequate head room. The magnetic locking device will be relocated such that the bottom of the locking device is 6' 8" above the floor. The Maintenance Manager will be responsible for the aforementioned actions. The Safety Chairperson will monitor compliance during the quarterly safety inspections. The results of the inspections will be reported to the Safety Committee via a performance improvement monitor.	2/23/11
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to	K 051		

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K 051	Continued From page 2 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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure smoke detectors were properly installed in 2 of 4 smoke compartments. The findings were: Observation of the fire alarm system on 1/25/11 between 2 PM and 4 PM showed two smoke detectors in the kitchen, and the detector in the front office, were installed closer than the 36 inches from a ventilation supply vent. The detectors were all installed less than 18 inches from vents. At 2:02 PM the maintenance manager reported he was not aware of the aforementioned	K 051	The facility will ensure that smoke detectors are properly installed. The 2 smoke detectors in the kitchen and the detector in the front office will be installed at least 36 inches from the ventilation supply vent. The Maintenance Manager will be responsible for the aforementioned actions. The Safety Chairperson will monitor compliance during the quarterly safety inspections. The results of the inspections will be reported to the Safety Committee via a performance improvement monitor.	3/14/11

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K 051	Continued From page 3 requirement.	K 051		
K 062 SS=E	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 on observation and staff interview the facility failed to ensure sprinklers were unobstructed in 1 of 4 smoke compartments. The findings were: Observation of the medication room on 1/25/11 at 2:32 PM showed the sprinkler was obstructed by the ceiling mounted light. The sprinkler was installed 10 inches from the light and the bottom of the deflector was not at, or below, the bottom of the light. The bottom of the deflector was 2 inches above the bottom of the light. At the time of observation the maintenance director said he was aware of the spacing requirement, but could not explain why the sprinkler had not been noticed during the annual inspection and modified.	K 062	The facility will ensure that sprinklers are unobstructed. The ceiling mounted light will be relocated in order to provide proper clearance from the sprinkler. The Maintenance Manager will be responsible for the aforementioned actions. The Safety Chairperson will monitor compliance during the quarterly safety inspections. The results of the inspections will be reported to the Safety Committee via a performance improvement monitor.	3/14/11
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 outlets in wet	K 147		

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K 147	Continued From page 4 locations had ground fault circuit interrupter (GFCI) protection in 2 of 4 smoke compartments. The findings were: Observation of the electrical system on 1/25/11 between 1:30 PM and 2:30 PM showed the electrical outlets in the kitchen housekeeping closet and kitchen dish room were located less than 6 feet from a sink. Further review showed the outlets did not have GFCI protection. At 1:45 PM the maintenance director reported he was aware of the requirement, but could not explain why the outlet had not been noticed and replaced.	K 147	The facility will ensure that electrical outlets in wet locations have ground fault circuit interrupter protection. The electrical outlets in the kitchen housekeeping closet and kitchen dish room will be relocated to outside of 6 feet from the sink. GFCI protection outlets will be installed. The Maintenance Manager will be responsible for the aforementioned actions. The Safety Chairperson will monitor compliance during the quarterly safety inspections. The results of the inspections will be reported to the Safety Committee via a performance improvement monitor.	3/1/11