STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/05/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

5/5/05

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building- Nursing Home Type V (000) with a complete wet sprinkler system. The facility is a single story building with one smoke barrier. The South Bighorn Hospital is adjacent to the nursing home with a 2-hour fire rated barrier and two 1 1/2-hour fire rated doors. The hospital is a Type II (111) without a sprinkler system. The four closest hospital rooms to the nursing homes 2-hour fire barrier are used for nursing home residents sleeping rooms. K6: Date of Plan Approval Nursing Home 1973, CAH 1956 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=37 ;SNF/NF=37 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association "CAH" Critical Access Hospital	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch sold-bonded core wood, capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018	This facility will ensure [illegible] corridor door openings resist the passage of smoke. Resident room #112 will have smoke barrier replaced at gap between the top edge of the corridor door and the door frame	

RECEIVED
MAY 03 2005
WYOMING DEPARTMENT OF HEALTH
HEALTH FACILITIES

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

Jackie Clauson — Administration — 4-29-05

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.

ACCEPTANCE OF MTG/POC WITH JACKIE CLAUSON/MAY ON 5/5/05 @ 2:57PM VIA TELECONFERENCE.

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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.3 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities as of March 13, 2006. This STANDARD is not met as evidenced by: Based on observations and staff interview on 4/5/05 between 12:30 PM and 3 PM, the facility failed to protect 1 of 35 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Resident room #112 had a gap between the top edge of the corridor door and the door frame that was greater than the allowed 1/8th of an inch. Maintenance staff verified door had a gap greater than 1/8th of an inch.	K 018	with smoke resistant barrier. Mainenance staff will evaluate all corridor doors for greater than 1/8th inch gap between top edge and door frame and any gaps in excess of 1/8" will have smoke barrier replaced. Monitored by Safety Officer through quarterly QA review.	5-2-05
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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025	This facility will ensure smoke barriers are constructed to provide at least a one-half hour fire resistance rating. Smoke barrier in the west corridor will have another 5/8" gypsum board placed and taped on other side of wood studs above the ceiling tile. All smoke barriers will be checked by Maintenance for	

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K 025	Continued From page 2 Based on observation, blue print review, and staff interview on 4/5/05 between 2 PM and 2:30 PM, the facility failed to protect 1 of 1 smoke barriers in accordance with NFPA 101 Section 19.3.7.3 and 8.3.2. The findings were: 1. The smoke barrier in the West corridor had gypsum board on only one side of the wood studs above the ceiling tile. Review of the facilities blue prints with the maintenance director revealed the smoke barrier was originally designed to be a 1 -hour fire rated barrier with one sheet of 5/8-inch gypsum board on each side of the wood studs. Maintenance staff verified the gypsum board was only on one side of the wood studs.	K 025	one-half hour fire resistance. Any barriers found not to meet this requirement will have additional fire barriers provided. Monitored by Safety Officer through quarterly Quality Improvement review.	4-25-05
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 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 on 4/5/05 between 1 PM and 2 PM, the facility failed to provide 1 of 4 hazardous areas with proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. The self-closing device on the soiled utility	K 029	This facility will ensure seperation of hazardous area from other spaces by smoke resisting partitions and doors. Self-closing device on soiled utility room door will be adjusted to proper closure and full latch. All hazardous area doors will be checked for proper closure. Those found to have improper closure or laching will be repaired or replaced as appropriate. Monitored by Safety Officer through quarterly Quality Improvement review.	4-6-05

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K 029	Continued From page 3 room near resident room #103 did not fully latch the door into the door frame. Maintenance staff verified the door did not fully latch into the door frame.	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on 4/5/05 between 8 PM and 8:30 PM, the facility failed to provide exit discharge lighting fixtures that prevent the loss of illumination if a single bulb failed for 1 of 8 exits in accordance with NFPA 101 Section 19.2.8. The findings were: 1. The South exit discharge light fixture near resident room #206 had two light bulbs which were not illuminated during the evening inspection.	K 045	This facility will ensure exit illumination. Bulbs will be replaced in south exit fixture. All exit lighting will be checked by Maintenance Staff and bulb replacement as appropriate. Monitored by Safety Officer through monthly exit lighting inspection and quarterly Quality Improvement reporting.	4-6-05