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
	535038	A. BUILDING _____ 01 - MAIN BUILDING 01 B. WING	08/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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: Type V (111) one story building with a complete automatic supervised dry sprinkler system and fire alarm system. K6: Date of Plan Approval: 1985 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=60;SNF/NF=60 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections	K 000		
K 018 SS=E	"NFPA" National Fire Protection Association 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 solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only 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 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roland Pack | TITLE: GM | (X6) DATE: 9-22-05

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 this POC with Roland Pack's GM on 9/26/05 @ 11 AM via telephone. [illegible]

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 8/9/05, the facility failed to protect 8 of 74 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. The following corridor doors had gaps between the top edge of the doors and the door frames, which were greater than the allowed 1/8th of an inch: a. At 8:24 AM, resident room #308. b. At 8:29 AM, resident room #311. c. At 8:37 AM, resident room #206. d. At 8:40 AM, resident room #105. e. At 9:11 AM, the mechanical room near resident room #200. f. At 9:17 AM, the mechanical room near resident room #201. 2. At 8:46 AM, the corridor door to resident room #108 had a latch bolt which would not insert into the strike plate, preventing the door from latching. 3. At 9:10 AM, the corridor door to the mechanical room near resident room #200 was equipped with a self-closing device which was not able to fully latch the door into the door frame. 4. Maintenance staff verified the findings.	K 018	K018 Doors protecting corridor openings in other required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ wood or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 1) Door #308, 311, 206, 105, 200, and 201 will have proper fire rated striping to meet all state requirements. 2) Room #108 strike plate will be properly fitted to the door latch and will catch properly for complete closure. 3) A new self-closing device will replace the old one that will be thrown away upon replacement with the new one. 4) Door inspection will be changed from monthly to bi-monthly. 5) Inspections will be completed by the Maintenance Director. 6) To ensure ongoing compliance findings of door inspections will be presented to QA committee quarterly.	09/09/2005
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		

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K 025	Continued From page 2 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 observations and staff interview on 8/9/05, the facility failed to maintain two of four smoke barriers in accordance with NFPA 101 19.3.7.3. The findings were: 1. At 9:30 AM, the vertical smoke barrier wall above the double doors near the physical therapy department had three unsealed cable penetrations above the ceiling tile. 2. At 9:51 AM, the vertical smoke barrier wall above the double doors near resident room #305 had an attic access door opening which passed through the wall. The door opening was covered by a 3/4-inch-thick sheet of plywood. The plywood sheet did not meet the minimum requirement of 1/2 hour fire resistance rating. 3. Maintenance staff verified the findings.	K 025	K025 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 tow 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. 1) All cables and holes be chalked and covered with fire rated silicone chalking. 2) Smoke Barrier walls in the attic will be inspected quarterly by the Maintenance Director. 3) ½ hour fire material self closing doors will be built and installed to cover access holes. The doors will be constructed of 2 x 4's with 5/8 sheet rock meeting the proper fire rating. 4) Smoke Barrier walls above ceiling tile will be inspected quarterly by Maintenance Director. 5) Holes will be sealed with fire rated silicone that meets all state and federal requirements. 6) The Administrator or General Manager will complete inspections quarterly to ensure compliance and report findings to QA quarterly.	09/20/2005
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	K 029		

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K 029	Continued From page 3 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 observations and staff interview on 8/9/05, the facility failed to ensure 1 of 9 hazardous areas had doors with self-closing devices in accordance with NFPA 101 Section 19.3.2.1. The findings were:	K 029	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1and/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. 1) A new door closure will be ordered and installed. The closure will be one that will shut automatically at all times, not allowing for any opportunity to have the door stay in the open position. Thus keeping the door closed at all times. 2) In-Service given by Dietary Manager to alert staff of the need to keep the door closed. 3) This procedure will be added to the orientation check off list and will be communicated to new hires by the Dietary Manager. 4) To ensure compliance Dietary Manager will monitor the door ensuring its closure at all times and report any necessary repairs to the Maintenance Director and the Administrator or General Manager. Findings will be reported to QA quarterly.	09/01/05
	1. At 7:45 AM, the kitchen utility storeroom door was noted to be equipped with a self-closing device that did not automatically close with the activation of the fire alarm system. The self-closure was equipped with a device that allowed the door to be held in the open position when fully opened. Maintenance staff verified the finding.			
K 056 SS=D	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	K 056		

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K 056	Continued From page 4 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 observations and staff interview on 8/9/05, the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1 and 5-13.8.1. The findings were: 1. At 8:03 AM, the exterior roof above the dining room exit had one sprinkler head installed. The roof was constructed of combustible materials and was 22 feet long. The maintenance director reported it looked as if a sprinkler head had been removed from the south wall.	K 056	K056 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 system. 1) A certified sprinkler company will be asked to install a new sprinkler head on the exterior roof above the dining room exit on the south wall. 2) The certified sprinkler company will also be asked to have a complete inspection of the sprinkler system competed to insure compliance of the system. 3) This will be added to the location map. 4) This will be inspected quarterly by the Maintenance Director and findings will be reported at the quarterly QA meeting.	09/20/05
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 on observations and staff interview on 8/9/05, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 2-2.6.2 and 5-6.5.2.3 respectively. The findings were:	K 062		

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K 062	Continued From page 5 1. The following locations had sprinkler heads with escutcheon plates missing: a. At 8:15 AM, 1 of 15 sprinklers in the dining room. b. At 8:32 AM, the restroom in resident room #301. 2. At 9 AM, the mesh on the top panel of the privacy curtain in the central supply measured less than the allowed 1/2 inch on the diagonal. 3. Maintenance staff verified the findings.	K 062	K062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 1) All sprinkler heads will be inspected quarterly by the Maintenance Director. 2) Missing Escucheon Plates have been replaced. 3) Mesh curtains have been removed. 4) Compliance will be monitored by findings from the quarterly inspection being reported in the QA meeting.	08/10/05
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations and staff interview on 8/9/05, the facility failed to provide a K type fire extinguisher in the kitchen when combustible cooking media was used in accordance with NFPA 10 Section 2-3.2. The findings were. 1. At 7:49 AM, the kitchen was not equipped with a "K" type fire extinguisher. Kitchen staff verified combustible cooking media was used in the kitchen. Maintenance staff verified the kitchen only had an "ABC" type extinguisher.	K 064	K064 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10 1) New K Type Fire Extinguisher was purchased and installed. 2) All kitchen staff was in-serviced and how to use the new Extinguisher. 3) Dietary manager will monitor that the proper type K fire extinguisher remains in the kitchen and any findings will be reported to the QA committee to ensure compliance.	09/01/05
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not	K 075		

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K 075	Continued From page 6 exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview on 8/9/05, the facility failed to limit the amount of soiled linen or trash collection receptacles in accordance with NFPA 101 Section 19.7.5.5. The findings were: 1. The following locations had a 32 gallon soiled linen receptacle and a 32 gallon trash collection receptacle stored within 64 square feet of each other: a. At 8:30 AM, the 100 hall alcove. b. At 8:35 AM, the 200 hall alcove. c. At 8:55 AM, the 300 hall alcove. 2. Maintenance staff verified the findings.	K 075	K075 Solid linen or trash collection receptacles do not exceed 32 gal in capacity. The average density of container capacity in a room or space does not exceed .5 gal. A capacity of 32 gal is not exceeded within any 64 sq ft area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal are located in a room protected as a hazardous area when not attended. 1) Soiled Linen containers located in the alcoves of the 100, 200 & 300 halls are used 3 times daily, once on each shift. The soiled linen containers are then emptied completely and cleaned properly. The containers are then placed back in the alcove where soiled linen is kept and emptied regularly throughout a 24 hour period to maintain a fresh scented smell. Trash cans were removed from the alcoves and placed in the dirty linen room. 2) All staff have been notified during an in-service on 8/31/05. 3) This will be monitored daily by the Maintenance Director, The Administrator, or the General Manager. To ensure compliance the findings will be discussed at the quarterly QA meetings.	09/01/05
K 145 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2.	K 145		

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K 145	Continued From page 7 This STANDARD is not met as evidenced by: Based on blueprint review, observations and staff interview on 8/9/05, the facility failed to limit functions connected to the life safety branch of the essential electrical system in accordance with NFPA 99 Section 3-4.2.2.2. The findings were: 1. At 8:19 AM, review of electrical blueprints revealed electrical panel LS was a Life Safety Branch circuit panel. Circuit #8 supplied power to the nurse call system, which is not a listed item for the Life Safety Branch. Maintenance staff verified the findings.	K 145	K145 The Type I EES is divided into critical branch, life safety branch, and the emergency system in accordance with NFPA 99. 3.4.2.2. 1) A certified electrician will be contracted to make the changeover. Circuit #8 will be changed to critical branch electrical panel. 2) All future wiring will be approved by a certified electrician. 3) The General Manager or Maintenance Director will monitor the certified electrician and report to the quarterly QA meeting to ensure compliance. 4) All works to be approved By the Appropriate State Depts.	09/09/05
K 147 SS=D	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 observations and staff interview on 8/9/05, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 110-26. The findings were: 1. At 8:21 AM, The mechanical room near the day room had cleaning supplies stored closer than the allowed three feet from the electrical panels. A tape outline was on the floor three feet in front of the panels to indicate that nothing should be stored in this area. The maintenance director acknowledged that nothing should be stored in front of the electrical equipment.	K 147	K147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. 1) The cleaning supplies were moved to the proper areas, 3 feet away from the electrical panels. 2) All Housekeeping and Maintenance personnel have been informed not to store anything in front of the electrical equipment. 3) This will be monitored daily by the Maintenance Director. 4) Findings of monitoring will be reported quarterly to the QA committee to ensure compliance.	09/08/05