STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - GOSHEN CARE CENTER B. WING _____	03/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE TORRINGTON, WY 82240

(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	K 000		

This Life Safety Code (LSC) survey was conducted on March 7, 2006, between 8:00 AM and 3:30 PM, using the existing section of the 2000 edition of the National fire Protection Association (NFPA) 101, Life Safety Code, as per the requirements of the Federal Register at 42CFR 483.70(a). This was a single story facility without a basement. It housed 75 beds and was constructed in 1998. It was of Type V (111) construction with a full automatic sprinkler system. It had appropriate smoke compartments and was fire separated from the adjacent hospital with a 2 hour rated fire wall. The findings included:

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K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 011	

If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2

To fill the approximately one inch gap existed at the top of the gypsum board of the fire wall separating the two buildings spray foam will be used. To ensure the fire walls stay within compliance this issue will be monitored through the PI Steering Committee. **This plan of correction will be completed no later than April 13, 2006.**

This Standard is not met as evidenced by:
Based upon observation and staff interview during the survey, it was determined that the facility failed to provide complete fire separation between the nursing home and the adjacent hospital. The findings included:

1. At approximately 10:30 AM on 3/07/06, it was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CED	3/23/2006

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.

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K 011	Continued From page 1 observed that approximately a one inch gap existed at the top of the gypsum board of the fire wall separating the two buildings. This was verified with a member of the maintenance staff.	K 011		
K 018 SS=F	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. This Standard is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide corridor doors that would resist the passage of smoke. The findings included:	K 018	18 of 45 resident rooms were not capable of being resistant to the passage of smoke; therefore new doors will be installed. 7 doors can be corrected by replacing the smoke seal. 11 doors must be replaced due to warping over 1/4". The plant operations staff will seal the remaining doors to make certain they resist the passage of smoke. To ensure the remaining door stay in compliance the plant operations staff will inspect the doors on a monthly basis through a preventative maintenance program. **This plan of correction will be completed no later than April 13, 2006.**	

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K 018	Continued From page 2 1. During the course of the survey, it was observed that 18 of 45 resident room doors were not capable of being resistant to the passage of smoke. These doors included 202, 204, 206, 208, 209, 213, 214, 215, 302, 306, 307, 308, 309, 312, 403, 409, 408, and 413. The above was verified with maintenance staff.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide smoke barrier doors at 3 of 3 sets in the nursing care area that would meet smoke barrier installation requirements. The findings included: 1. At 1:30 PM on 03/07/06, it was found that a gap of approximately one inch existed between the doors to the 300 wing when they were closed. The gasketing in place was not covering this opening.	K 027	1) It was found that a gap of approximately one inch existed between the doors to the 300 wing when closed. Smoke resistant stripping will be placed in the aforementioned gap. To ensure the smoke seals stay within compliance this issue will be scheduled and monitored through a preventative maintenance program. **This plan of correction will be completed no later than April 13, 2006.** 2) It was observed that 3 of 3 sets of smoke barrier doors did not contain wired glass windows. These windows will be replaced with fire rated, wired glass. The plant operations staff will inspect these doors/windows on their scheduled daily rounds. **This plan of correction will be completed no later than April 13, 2006.**	

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K 027	Continued From page 3 2. It was further observed that 3 of 3 sets of smoke barrier doors were 20 minute fire rated and the windows in these doors did not contain wired glass windows. It also could not be verified that these windows contained fire rated glass. This matter was verified by a maintenance staff member and was discussed extensively with the Administrator and other members of the maintenance staff during the exit interview.	K 027		
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 upon observation and staff interview during the survey, it was determined that the facility failed to provide hazardous areas with proper functioning doors. The findings included: 1. It was observed at 11:00 AM on the day of the survey, that the door to the clean linen room at the laundry was not latching under the power of its self closing device.	K 029	1) It was observed that the door to the linen room at the laundry was not self closing under the power of its self closing device. Manual adjustments will be made to the self closing device in order to make the door self close. To ensure these doors maintain the ability to self close the Safety Committee will inspect them on a monthly basis. **This plan of correction will be completed no later than April 13, 2006.** 2) It was observed that the door between the boiler room and generator room was wired in an open position. The wire will be removed. To ensure this door remains in compliance the Plant Operations staff will inspect them on their scheduled daily rounds. Also, a sign stating: "This door must remain closed," will be placed on the door. **This plan of correction will be completed no later than April 13, 2006.**	

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K 029	Continued From page 4 2. It was also observed at 11:15 AM on the day of the survey, that the door between the boiler room and generator room was wired in the open position. These matters were verified with maintenance staff at these times.	K 029		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based observation and staff interview, it was determined that the facility failed to maintain fire dampers in accordance with NFPA 90A section 3-4.7. The findings included: Based upon maintenance staff interview it was determined that the fire dampers at the central storage area had not been properly maintained. To meet this requirement "At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked ; and moving parts shall be lubricated as necessary."	K 067	It was determined that the fire dampers at the central storage area had not been properly maintained. To correct this deficiency a policy will be written stating, "At least every 4 years, fusible links shall be removed, all dampers shall be operated to verify that they fully close, and moving parts shall be lubricated as necessary." This issue will be scheduled and monitored through a preventative maintenance program. **This plan of correction will be completed no later than April 13, 2006.**	

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K 130	Continued From page 5	K 130		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based upon observation it was determined during the survey that the facility failed to secure a pressure vessel. The findings included: 1. At approximately 10:45 AM on the day of the survey, a carbon dioxide bottle was setting unsupported on the floor of the employee lounge. This was verified with maintenance staff at that time.	K 130	It was observed that a carbon dioxide bottle was sitting unsupported on the floor of the employee lounge. To correct this deficiency the bottle will be chained up. A sign will also be placed in the area of the bottles stating, "These bottles must remain chained." The staff will be educated concerning this issue. To ensure the bottles remain in compliance the plant operations staff will inspect them on their scheduled daily rounds. **This plan of correction will be completed no later than April 13, 2006.**	
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This Standard is not met as evidenced by: Based upon safety systems record review and staff interview during the survey, it was determined that the facility failed to provide a policy in keeping with the above requirements	K 154	It was observed that the facility has failed to provide a policy to instruct the staff of the procedure to follow if the automatic sprinkler system (154) or the fire alarm system (155) were out of service. A policy and procedure will be written to establish fire watches and other necessities in these situations. A check list will be developed for fire watches and the staff will be informed of the new policy/procedure. The Safety Committee will maintain this policy and continue the education of the staff. **This plan of correction will be completed no later than April 13, 2006.**	

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K 154	Continued From page 6 when the automatic sprinkler system is out of service for 4 hours in a 24 hour period. This was verified with maintenance staff at that time.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This Standard is not met as evidenced by: Based upon safety systems record review and staff interview during the survey, it was determined that the facility failed to provide a policy in keeping with the above requirements when the automatic fire system is out of service for 4 hours in a 24 hour period. This was verified with maintenance personnel at that time	K 155	It was observed that the facility has failed to provide a policy to instruct the staff of the procedure to follow if the automatic sprinkler system (154) or the fire alarm system (155) were out of service. A policy and procedure will be written to establish fire watches and other necessities in these situations. A check list will be developed for fire watches and the staff will be informed of the new policy/procedure. The Safety Committee will maintain this policy and continue the education of the staff. **This plan of correction will be completed no later than April 13, 2006.**	