DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 II (222) K6: Date of Plan Approval: 1972 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=170;SNF/NF=170 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K018	
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 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.	K 018	1. Rooms #304, #303, #215, and #201 will have their doors repaired or replaced as needed. Third floor medication room door will be replaced with a smoke resistant door. The basement housekeeping cart room corridor door will not be impeded by blankets or any other item. Resident room #303 will have a new latch bolt installed with new door. 2. All residents have the potential to be affected by this deficiency. 3. All facility doors will be audited once a month for three months and quarterly thereafter by maintenance staff to ensure compliance. Maintenance Director is responsible for overall compliance. 4. Results of audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance date: July 15, 2005	

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

Lucrecia Patterson, NHA — Executive Director — 6/27/05

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 THE POC WITH LUCRECIA PATTERSON, NHA, ON 6/30/05 @ 11AM VIA TELECONFERENCE

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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 6/3/05 between 8 AM and 11 AM, the facility failed to protect 6 of 152 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Gaps were observed between the top edge of corridor doors and the door fromes of resident rooms #309, #303, #215, and #201. These gaps were greater than the allowed 1/8th of an inch. 2. The third floor medication room corridor door was equipped with a louver and was not smoke resistant as required by the Code. 3. The basement housekeeping cart room corridor door was impeded by blankets. 4. The corridor door to resident room #303 was equipped with a latch bolt that would not insert into the strike plate and, therefore, did not fully latch the door into the door frame as required by the Code. 5. Maintenance staff verified the findings.	K 018		
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	K 029		

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/3/05 between 10 AM and 11 AM, the facility failed to provide 1 of 21 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 corridor door for the second floor bio-hazard room did not fully latch the door into the door frame as required by the Code. Maintenance staff verified these findings.	K 029	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K029 1. The self closing device on the corridor door for the second floor bio-hazard room will be repaired to ensure proper closure. 2. All residents have the potential to be affected by this practice. 3. An audit of all doors with self closures will be conducted monthly for three months and quarterly thereafter by maintenance staff to ensure compliance. Maintenance Director is responsible for overall compliance. 4. Results of audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	
K 038 C=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times as defined in section 7.1.19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/2-3/05, the facility failed to provide paths of egress unobstructed and accessible at all times in accordance with NFPA 101 Section 19.2.1 and 7.1.10.1. The findings were: 1. On 6/2/05 at 3:30 PM, 6 doors laying on their sides and 2 carts obstructed the basement corridor near the maintenance shop. The obstructions were observed in these locations for more than one hour. 2. On 6/3/05 at 10:51 AM, The exit discharge path near resident room #118 was obstructed by a table and 6 chairs. Maintenance staff reported residents continually pull the table and chairs under the awning that is in front of the exit.	K 038	K038 1. All items in basement corridor near maintenance shop have been removed. The table and chairs in the exit discharge path near room #118 have been removed. 2. All residents have the potential to be affected by this practice. 3. All corridors will be audited weekly for one month, monthly for three months, then quarterly thereafter by maintenance staff to ensure compliance. Exit door obstructions will be monitored daily for 2 weeks, then monthly thereafter by maintenance staff to ensure compliance. Maintenance Director is responsible for overall compliance. All appropriate staff will be inserviced on egress. 4. Results of audits and inservices will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance date: July 15, 2005	

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K 038	Continued From page 3 3. Maintenance staff verified the findings.	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/3/05 between 11 AM and 1110 AM, the facility staff were not familiar with the emergency actions required under varied fire conditions in accordance with NFPA 101 Section 19.7.1.2 and 7.1.10.1 The findings were: 1. It was observed that the corridors were not accessible and unobstructed as required by the Code. During the fire drill on the second floor, the "A" and "B" wing corridors were obstructed by two housekeeping carts. Maintenance staff verified these findings.	K 050	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K050 1. All Housekeeping carts will be removed from the corridors during fire drill to prevent obstruction. 2. All residents have the potential to be affected by this practice. 3. All corridors will be monitored during fire drills by management staff to ensure compliance and on the spot education done as needed. All Housekeepers will be inserviced regarding not leaving carts in hallway. Maintenance Director is responsible for overall compliance. 4. Results of fire drills will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to 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	K 051		

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K 051	Continued From page 4 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. Except for self-testing systems, fire alarm systems are manually tested monthly. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained periodically and records of maintenance 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 record review, observation, and staff interview on 6/3/05 between 10 AM and 11 AM, the facility failed to test and document the installed fire alarm system in accordance with NFPA 72 Section 5-2.2.3.1.1. The findings were: 1. Review of the fire alarm records revealed the central station placard had expired on March 31, 2005. During observation of the fire alarm panel it was determined that the central station placard was not posted within 36 inches of the fire alarm panel as required by the Code. Maintenance staff verified these findings.	K 051	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K051 1. A new central station placard will be acquired and posted within 36 inches of the fire alarm panel. 2. All residents have the potential to be affected by this practice. 3. Maintenance will monitor placard monthly to ensure timely replacement before expiration. Maintenance Director responsible for overall compliance. 4. Results of monitoring will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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K 062	Continued From page 5 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 6/2-3/05, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 2-2.6.2 and NFPA 25 Section 2-4.1.4 respectively. The findings were: 1. On 6/2/05 at 2 PM, it was observed that the facility did not have two spare sprinkler heads to replace each type installed in the building as required by the Code. The spare sprinkler cabinet held one spare 200 degree upright head and did not have any spare 200 degree sidewall heads to replace the heads in the housekeeping office and generator room. 2. On 6/3/05 between 8 AM and 10 AM, the closet in resident room #314 and the second floor clean linen room had storage closer than the allowed 18 inches to the sprinkler deflector. 3. On 6/3/05 between 9:30 AM and 11 AM, resident room #223 and the sprinkler head in the corridor near resident room #209 did not have escutcheons that were set flush to the wall as required by the manufactures listed assembly. 4. Maintenance staff verified the findings.	K 062	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K062 1. Two spare sprinkler heads to replace each type installed in the building will be acquired. All items above the 18 inches in closets and clean linen rooms will be removed. Escutcheons will be replaced on sprinkler heads near rooms #223 and #209. 2. All residents have the potential to be affected by this practice. 3. An audit of spare sprinkler heads will be conducted quarterly by maintenance staff to ensure compliance. All closets and linen rooms will be audited weekly for one month and quarterly thereafter by maintenance staff to ensure compliance. All appropriate staff will be inserviced regarding 18 inch rule in closets and linen rooms. Escutcheons will be audited monthly for three months and quarterly thereafter by maintenance staff to ensure compliance. Maintenance Director is responsible for overall compliance. 4. Results of audits and inservices will be brought to the monthly Performance Improvement Committee for review, comments and suggestions. 5. Compliance Date: July 15, 2005	
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, 9.7.4.1, NFPA 10	K 064		

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K 064	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/3/05 between 10:30 AM and 11 AM, the facility failed to maintain and test 1 of 22 portable fire extinguisher in accordance with NFPA 10 Table 5-2. The findings were. 1. The K-type portable fire extinguisher in the kitchen was manufactured in 1999 and had not receive a five year hydrostatic test in 2004 as required by the Code. Maintenance staff verified the findings.	K 064	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K064 1. The K type portable fire extinguisher in the kitchen will receive a five year hydrostatic test. 2. All residents have the potential to be affected by this practice. 3. All fire extinguishers will be audited monthly by maintenance staff to ensure compliance. Maintenance Director is responsible for overall compliance. 4. Results of the audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/3/05 at 8:12 AM, The facility failed to maintain the essential electrical system in accordance with NFPA 99 Section 3-5.2.2.3. The findings were: 1. The third floor medication refrigerator was not supplied with emergency power as required by the Code. Maintenance staff verified the findings.	K 130	K130 1. All unit medication refrigerators will be supplied with emergency power. 2. All residents have the potential to be affected by this practice. 3. Medication refrigerators will be monitored during emergency power tests monthly for three months to ensure they are working appropriately by maintenance staff. Maintenance Director is responsible for overall compliance. 4. Results of tests will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: September 1, 2005	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with NFPA 99. 8.6.4.2	K 141		

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K 141	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/3/05 between 9 AM and 10 AM, the facility failed to post NO SMOKING signs in areas where oxygen was stored in accordance with NFPA 99 Section 8.6.4.2. The findings were: 1. The second floor oxygen storage room was not posted with a NO SMOKING sign. Maintenance staff verified the findings.	K 141	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K141 1. The second floor oxygen storage room will be posted with a no smoking sign. 2. All residents have the potential to be affected by this practice. 3. All doors will be audited biweekly for No Smoking signs where oxygen is stored or in use. All appropriate staff will be inserviced on posting of signs for oxygen. Maintenance Director is responsible for overall compliance. 4. Results of audits and inservices will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/2-3/05, the facility failed to maintain the installed emergency generator in accordance with NFPA 99 Section 3-4.4.1.1. The findings were: 1. An emergency generator transfer test was conducted on 6/2/05 at 3:25 PM which revealed the generator transferred the electrical load in 12 seconds and not within 10 seconds as required by the Code. A second test was performed on 6/3/05 at 10:45 AM and again the generator did not transfer the supply service until 12 seconds had elapsed. Maintenance staff verified the findings.	K 144	K144 1. The generator will be repaired to transfer the electrical load within 10 seconds. 2. All residents have the potential to be affected by this practice. 3. A generator transfer test will be conducted weekly for one month and then monthly thereafter by maintenance staff to ensure compliance with transfer time. Maintenance Director responsible for overall compliance. 4. Results of tests will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions.	

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K 147	Continued From page 8	K 147	5. Compliance Date: July 15, 2005	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be 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 6/2-3/05, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8 and 517-20 respectively. The findings were: 1. On 6/2/05 at 2:15 PM, it was observed that temporary flexible wiring was replacing permanent fixed wiring in the medical records office. A surge protector attached to a wall was supplying power to a computer. 2. On 6/2/05 at 2:20 PM, the medical records store room electrical outlet near the sink was not equipped with a GFCI outlet as required by the Code. 3. Maintenance staff verified the findings.	K 147	Disclaimer "This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." K147 1. The surge protector attached to the wall in Medical Records has been removed. The Medical Records store room electrical outlet near the sink has been equipped with a GFCI outlet. 2. All residents have the potential to be affected by this practice. 3. All rooms will be audited by maintenance staff monthly for three months for surge protectors attached to the wall and the need for GFCI outlets. Maintenance Director is responsible for overall compliance. 4. Results of audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: July 15, 2005	