DEPARTMENT OF HEALTH AND HL .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2006
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
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

RECEIVED
APR 26 2006
WYOMING DEPT OF C S FACILITY
HEALTH FACILITIES

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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) single story building with a automatic complete supervised wet sprinkler system and fire alarm system K6: Date of Plan Approval: 1967 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 "NFPA" National Fire Protection Association	K 000	ADDITION & ACCEPTANCE OF THIS POC WITH PAT MILLER, NHA, 04/28/06 @ 8:30AM VIA TELECONFERENCE.	

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

Patricia Ann Miller NHA — 4-26-06

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 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 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 on observations, the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 4/03/06 between 11:30 Am and 12:42 PM revealed the following locations had corridor doors with gaps between the top edges of the doors and their associated door frames, which were greater than 1/8 inch: a. The administrator's office. b. Resident room #25. c. The CEO's office. 2. Observation on 04/03/06 at 11:52 AM revealed	K 018	This facility strives to protect the corridor system in accordance with NFPA 101, Section 19.3.6.3. This will be accomplished by: 1. Doors to (a) the administrator's office, (b) Resident Room #25, and (c) the CEO's office have been repaired WITH GAPS. Maintenance Director will be in-serviced on the need to monitor all doors for gaps. This will be added to the Preventative Maintenance Book, Maintenance Director and Administrator are to monitor. Safety committee will review monthly to maintain compliance. Results will be reviewed by the Quality Assurance Committee. 2. Room 24 has been repaired. All doors will be monitored to maintain the corridor system's integrity per safety code. THE STRIKE PLATE WAS ADJUSTED BY MAINTENANCE STAFF.	4/25/06

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K 018	Continued From page 2 the latch bolt for the corridor door to resident room #24 would not insert into the strike plate on the door frame.	K 018		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation the facility failed to protect one of one hoist ways in accordance with NFPA 101 Section 8.2.5.2. The findings were: 1. On 04/03/06 at 1:47 PM, the hoist way basement door was observed to be propped open with a pencil stuck into a hole in the shelf next to the door. The hole in the shelf was worn smooth from continual use.	K 020	This facility strives to protect one of the hoist ways in accordance with NFPA 101, Section 8.2.5.2. This will be accomplished by: 1. Laundry staff, as well as all staff, will be in-serviced on the purpose of the hoist way door and the importance of not blocking it open. The blocking mechanism will be removed. Maintenance to check daily to ensure that the hoist way is not being propped open. The safety committee is to review monthly, results will be reviewed by the Quality Assurance Committee quarterly to ascertain the need to re-inservice staff. Laundry supervisor is also to monitor.	5/18/06

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K 027 SS=D	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 on observation, the facility failed to protect one of one attic smoke barrier door in accordance with NFPA 101 Section 19.2.2.2.6 and 3.3.20. The findings were: 1. On 04/03/06 at 2:23 PM, the self-closure device on the attic smoke barrier door located in the administrators office was impeded by electrical wires running through the door frame.	K 027	This facility strives to protect the attic smoke barrier to meet the intent of NFPA 101, Sections 19.2.2.2.6 and 3.3.20. This will be accomplished by: 1. Maintenance has assessed the smoke barrier door and will move the wires and repair the door frame to meet the integrity of the smoke barrier door. Maintenance is to monitor the effectiveness of the attic smoke barrier by adding it to the Preventative Maintenance Book. The Safety Committee will review monthly. The results will be reviewed at quarterly QA Committee meetings. Administrator and Maintenance Director to monitor.	4/30/06
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review, the facility failed to test the emergency battery light system in accordance with NFPA 101 Section 7.9.3 and 7.9.2.1 respectively. The findings were:	K 046	This facility will ensure that emergency lighting of at least 1-1/2 duration is provided in accordance with Section 7.9. This will be accomplished by: 1&2. Maintenance will complete the battery testing and make the necessary adjustments to meet the regulations and ensure the battery system is working properly. The 90 minute test	5/18/06

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K 046	Continued From page 4 1. Review of emergency battery light testing records revealed the annual 90 minute emergency battery light test had not been performed in the past year. The annual test was last performed in February, 2005. 2. Review of emergency battery light testing records revealed the monthly 30 second emergency battery light test had not been performed since August, 2005.	K 046	K046 Continued will be completed annually and the 30 second tests will be completed monthly. A record of this will be kept in the Preventive Maintenance Book. The Safety Committee will review monthly. The results will be reviewed at quarterly QA Committee meetings. Administrator and Maintenance Director to monitor.	
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 record review, the facility failed to conduct quarterly fire drills on each shift in accordance with NFPA 101 Section 19.7.1.2. The finding was: 1. Review of the fire drill records revealed the second shift had not conducted a fire drill during the fourth quarter of 2005.	K 050	This facility strives to meet the intent of NFPA 101, Section 19.7.1.2 by conducting quarterly fire drills on each shift. 1. A fire drill was conducted on the 2nd shift on April 4, 2006, and will be completed on a quarterly basis on each shift. Maintenance is to monitor, Safety Committee is to review monthly, and the QA committee will address on a quarterly basis. Administrator and Maintenance to monitor.	5/18/06

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K 051 SS=F	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 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 record review, the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The findings were: 1. Review of the maintenance testing records revealed the annunciator panel, alarm notification appliances, manual fire alarm boxes, and smoke detectors had not been tested in the past 12 months as required by the Code. The facility did not have a copy of their last testing records.	K 051	This facility strives to meet the intent of NFPA 72, Table 7-3.2. This will be accomplished by: 1,2,3, & 5. The facility has a contract with a new fire and sprinkler system company. All testing addressed in 1,2,3, & 5 of this violation have been completed. The company will automatically complete the quarterly testing. Maintenance will review the preventative maintenance log to ensure that time lines are met. The safety committee will review monthly for compliance. The results will be reviewed quarterly by the QA committee. Administrator and Maintenance to monitor. 4. Maintenance will be in-serviced on the need to test every fire pull station in conjunction with fire drills. Safety committee will review monthly for compliance, the QA committee will review quarterly. Administrator to monitor. FIRE ALARM SYSTEM WILL BE ACTIVATED MONTHLY WITH FIRE DRILLS.	5/18/06 5/18/06

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K 051	Continued From page 6 2. Review of the maintenance testing records revealed the smoke detector sensitivity test had not been conducted in the past 2 years as required by the Code. The facility did not have a copy of their last testing records. 3. Review of the maintenance records revealed the annunciator panel's battery load voltage test had not been performed in the past 6 months as required by the Code. 4. Review of the fire drill testing records revealed the monthly fire alarm receiver test had not been performed for the months of May, August, September, and October 2005, and March 2006. 5. Review of the fire sprinkler testing records revealed the quarterly supervisory signal device test was not conducted during the second and third quarters of 2005.	K 051		
K 056 SS=E	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 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:	K 056	This facility strives to meet the intent of NFPA 101, Section 19.3.5.1, 9.7.1.1, NFPA 13, Section 5-1.1 and 5-13.8.1. This will be accomplished by: 1,2,3. In order to meet this regulation the facility will request a waiver to allow time for completion. Please see attached waiver letter. Administrator and Owner to monitor. WAIVER DATES: SUBMIT PLANS 6/1/06 START PROJECT 8/1/06 FINAL INSPECTION 11/1/06 PROJECT APPROVAL 11/16/06	5/18/06 6/1/06

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K 056	Continued From page 7 Based on observations, the facility was not fully sprinkled as required by NFPA 101 Section 19.3.5.1, 9.7.1.1, NFPA 13 Section 5-1.1 and 5-13.8.1. The finding was: 1. Observation on 4/03/06 between 1:16 Pm and 1:32 PM revealed three exterior canopies that were not constructed of non-combustible or limited combustible material, were wider than 4 feet, and did not have sprinkler coverage. Observation showed the roof, itself, was constructed of pine rafters and plywood sheathing. a. The roof over the basement exit. b. The roof over the west exit. c. The roof over the east exit. 2. Observation on 04/03/06 at 1:34 PM revealed the roof over the courtyard smoking area was not constructed of non-combustible or limited combustible material, was wider than 4 feet, and did not have sprinkler coverage. Observation showed the roof was constructed of pine rafters and corrugated fiberglass roofing. 3. On 04/03/06 at 1:10 PM, the two walk-in refrigerator units in the kitchen did not have sprinkler coverage as required by the Code.	K 056		

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K 062 SS=F	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, the facility failed to test the installed sprinkler system in accordance with NFPA 25 Section 9-2.6, and 9-2.7 respectively. The findings were: 1. Review of the fire sprinkler testing records revealed the quarterly main drain and waterflow alarm tests were not conducted during the second and third quarters of 2005.	K 062	This facility strives to meet and maintain the intent of NFPA 25, Section 9-2.6, and 9-2.7 respectively. This will be accomplished by: 1. The facility has a contract with a new fire and sprinkler system company. The company will automatically complete the quarterly testing. Maintenance will review the preventative maintenance log to ensure that time lines are met. The safety committee will review monthly for compliance. The results will be reviewed quarterly by the QA committee. Administrator and Maintenance to monitor.	5/18/06
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, the facility failed to inspect 12 of 12 portable fire extinguisher in accordance with NFPA 10 Section 4.3.4.2. The findings were: 1. Observation on 4/03/06 at 11:44 AM revealed the service tag on the portable fire extinguisher	K 064	This facility strives to meet and maintain the intent of NFPA 10, Section 4.3.4.2. This will be accomplished by: 1. Maintenance was in-serviced on the importance of inspecting fire extinguishers on a monthly basis and has been added to the Preventative Maintenance check list. Safety Committee will review on a monthly basis and the QA committee will review quarterly for compliance.	5/18/06

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K 064	Continued From page 9 near resident room #24 did not document that a monthly inspection had occurred since the annual service was done in October, 2005. Interview with a member of the maintenance staff at the time of the observation revealed none of the extinguishers had been inspected. Further observations confirmed none of the twelve extinguishers had been inspected on a monthly basis.	K 064		
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 on observation, the facility failed to maintain the gas-fire boiler louver system in accordance with NFPA 101 Section 19.5.2.1, 9.2.2, and NFPA 54 Section 6.9.5. The finding s were: 1. Observation on 4/03/06 at 1:50 PM revealed the arm to the mechanical louvers that supply combustion air to the gas-fire boiler had been removed.	K 067	This facility strives to meet and maintain the intent of NFPA 101, Section 19.5.2.1, 9.2.2, and NFPA 54, Section 6.9.5. This will be accomplished by: 1. The mechanical louvers were repaired on April 10, 2006. This has been added to the preventative maintenance book so maintenance can monitor. Safety Committee will review on a monthly basis and the QA committee will review quarterly for continued compliance.	5/18/06

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K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain the installed commercial cooking equipment and protection system in accordance with NFPA 96 Section 11.2.1. The findings were: 1. Review of the commercial cooking equipment testing records revealed the semi-annual inspection and service of the fire extinguishing system had not been performed in the past 6 months as required by the Code. According to the records, the last test was performed in October, 2005.	K 069	This facility will ensure that cooking facilities are protected in accordance with Section 9.2.3. This will be accomplished by: 1. The contracted testing company has been notified and will ensure the facility is on their semi-annual schedule. ~~They will visit the facility this week to test the system~~. This will be added to the preventative maintenance book so maintenance can monitor. Safety Committee will review on a monthly basis and the QA committee will review quarterly for continued compliance.	5/18/06
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, the facility failed to maintain an electrical system installed in accordance with NFPA 70 Section 110.27. The findings were: 1. Observation on 4/03/06 between 1210 PM and 12:51 PM revealed the following locations had damaged electrical receptacles: a. A cracked receptacle near the window in resident room #23. b. Char marks were visible on the receptacle in	K 147	This facility strives to meet and maintain the intent of NFPA 70, Section 110.27. This will be accomplished by: 1a. The cracked receptacle near the window in resident room #23 was replaced the day of survey. 1b. The receptacle in the dining room near the television set was replaced the day of survey. Maintenance will monitor that all receptacles are in good working order and not in need of repair or	4/3/06 4/3/06

DEPARTMENT OF HEALTH AND HUM .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

(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 147	Continued From page 11 the dining room near the television set.	K 147	K147 Continued replacement. This will be monitored on a weekly rounds basis. Safety Committee will review on a monthly basis and the QA committee will review quarterly for continued compliance. Any areas of non-compliance will be reviewed by the QA committee to assess the need for policy or procedure change..	