STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 (111) two story building with a complete automatic supervised wet sprinkler system and fire alarm system. K6: Date of Plan Approval: 1981, 1992 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=128;SNF/NF=128 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	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the 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. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual. Rockwood POC w/ Richard Summerville Jr, MNTL Director, on 05/15/06 @ 10 AM & Told him a waiver is required for K-006	
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to provide flame retardant interior decorations in accordance with NFPA 101 Section 19.3.3.1 and 10.3.5. The finding was: 1. On 05/03/06 at 9:55 AM, the corridor door to resident room #13 was covered with a plush blanket. Maintenance staff reported the blanket was not flame retardant.	K 014	The facility will continue to provide flame retardant interior decorations. 1. The plush blanket was removed from the door of room #13 on 5/4/06. 2. Materials that are not fire retardant will not be placed in a manner that covers any corridor door. 3. Plant Operations staff will monitor during regular hazard surveillance rounds. POC accepted w/ Richard Summerville Jr, MNTL Director, on 6/15/06 @ 9:30 AM	5/4/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenna Kaiser, NHA — TITLE: Administrato — (X6) DATE: 5/31/06

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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WYOMING DEPT OF HEALTH
HEALTH FACILITIES

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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. On 05/03/06 at 11:23 AM, the corridor door to resident room #211 would not latch without excessive pressure. 2. On 05/03/06 at 12:15 PM, the corridor door to the basement data/telephone room was equipped with a self-closing device which was not able to fully latch the door into the frame.	K 018	Doors protecting corridors openings will resist the passage of smoke. 1. A new door has been ordered and will be replaced by an outside contractor on or before date listed. 2. Adjustments to the telephone/data room door closer were completed and operationally checked by plant operations staff on 5/17/06. Proper operation of corridor doors will be checked and monitored by plant operations staff during hazardous surveillance rounds.	6/17/06

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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 observations, the facility failed to protect 2 of 16 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3 and 8.3.4.1. The finding was: 1. On 05/03/06 at 9:51 AM, the first floor east smoke barrier double doors were equipped with self-closing devices which were not able to fully latch the doors into the frame.	K 027	Smoke barrier doors will automatically close and provide smoke separation. 1. New panic bar hardware has been ordered and will be installed by outside contractor by date listed. Proper operation of smoke doors will be checked and monitored by plant operations staff during monthly smoke door preventive maintenance (PM) checks.	6/17/06

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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 on observations, the facility failed to separate 7 of 15 hazardous areas from other spaces by smoke-resistant doors in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. On 05/03/06 between 10 Am and 2 PM, the following corridor doors were equipped with self-closing devices which were not able to fully latch the doors into the frames: a. The first floor clean utility rooms north door b. The basement physical therapy mechanical room 2. On 05/03/06 between 9 AM and 2:30 PM, the following corridor doors were equipped with self-closing devices which were impeded from closing: a. The lobby store room was impeded by a rope attached to the wall b. The south wing house keeping storage room by a wood wedge c. The basement medical records store room was impeded by a cardboard box	K 029	Hazardous areas will be protected with self closing doors. 1. The closer and latch assembles were adjusted for proper operation by Plant Operations staff for the flowing doors on or before date listed. a. The first floor clean utility room north door b. The basement physical therapy mechanical room. 2. Removed impediments on the following doors on or before 5/4/06. a. Staff was in-serviced on 5/19/06 not to use rope or any other device to impede door closing. b. Staff was in-serviced on 5/19/06 not to use door stop or any other device to impede door closing. c. Box was moved and in-serviced medical records staff not to use box or any other device to hold door open. 3. Items in patient room 23S were removed to an appropriate location for storage on or before 5/26/06. 4. Tape was removed on 5/4/06 and staff in-serviced on 5/19/06 not to impede latching devices on doors on or before date listed. Will be monitored by plant operations staff during hazardous surveillance rounds.	5/26/06

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K 029	Continued From page 4 3. On 05/03/06 at 1:44 PM, resident room #233 was storing 6 mattress and 4 upholstered chairs. The corridor door was not a 1-hour rated door and it was not equipped with a self-closing device as required for hazardous areas. 4. On 05/03/06 at 11:45 AM, the second floor store room near resident room #219 had a piece of tape over the latch bolt preventing the door from latching.	K 029		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain 3 of 24 exits signs in accordance with NFPA 101 Section 7.10.5.2. The findings were: 1. On 05/03/06 between 10 AM and 12 PM, the following exit signs were not maintained with both light bulbs continuously illuminated: a. The exit sign near resident room #8 b. The exit sign near resident room #28 c. The ground level exit sign in the north stair tower	K 047	Exit signs are displayed with continuous illumination and will be served by the emergency lighting system. 1. Bulbs in the following exit signs were replaced by Plant Operations staff. Inspection and operation of all exit signs in the facility was conducted by Plant Operations staff on 5/13/06. a. The exit sign near resident room #8 b. The exit sign near resident room #28 c. The ground level exit sign in the north stair tower This will be monitored monthly through the addition of inspection of exit light operation to monthly smoke door operation preventive maintenance tasks, completed by Plant Operations staff.	5/13/06

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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, 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. The finding was: 1. On 05/03/06 at 3:06 PM, the three Hoyer lifts in the corridor near resident room #2 were not removed from the corridor during the fire drill as required by the Code.	K 050	Means of egress will be free of obstacles; staff will move any carts or items from hallways in the event of a fire. 1. The LTCC staff was in-serviced on moving lifts and any other items out of hallways during a fire to provide clear means of egress. The effectiveness of this in-service was validated during a fire drill conducted on 5/18/06 during a CMS validation survey. Staff compliance will be monitored by LTCC Director of Nursing or Administrator through routine fire drill evaluations.	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 finding was: 1. On 05/03/06 at 3:15 PM, review of the maintenance testing records revealed the smoke dampers had not been tested in the past 12 months as required by the Code.	K 051	Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. 1. Smoke dampers were tested and documentation filed in LTCC manual. Smoke damper testing will be entered and initiated by TMS, a work order and PM management system to insure timeliness of testing. Will be monitored by plant operations staff during PM completion.	5/23/06

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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: Based on observations, the facility had not installed the sprinkler system in accordance with NFPA 13 Section 5-6.4.1.1 and 5-6.5.1.2 respectively. The findings were: 1. On 05/03/06 between 9 AM and 2 PM, the following areas had sprinkler deflectors located less than the minimum 1 inch below the ceiling: a. 1 of 2 in the front entrance b. 1 of 2 in the pantry c. 8 of 8 at the top of the atrium d. 1 of 2 in resident room #245 2. On 05/03/06 at 9:35 AM,the pantry had 2 of 2 sprinkler heads obstructed by permanently mounted fluorescent light fixtures. The lights were four inches below the bottom of the sprinkler deflectors and not the minimum distance of 2 feet from the sprinklers. The lights were 2 inches from the sprinklers. 3. On 05/03/06 at 10:36 AM, the skylight ceiling of the atrium did not have sprinklers as required by	K 056	The automatic sprinkler system is installed in accordance with NFPA 13 and the system is maintained in accordance with NFPA 25. 1. After completing a facility wide survey to identify all additional sprinkler heads not meeting requirements. The sprinkler heads will be adjusted and/or replaced by an outside contractor to provide 1 inch of clearance. Due to contractor prior commitments we will not be able to complete this item by 6/17/06. a. 1of 2 in the front entrance b. 1 of 2 in the pantry c. 8 of 8 at the top of atrium d. 1 of 2 in resident room #24S In order to complete this K-tag we will need a time waiver based on the following milestones. Survey of additional heads not meeting requirements will be completed by 7/31/06. Contractor will adjust and/or replace heads and be completed by 10/31/06. 2. Lights were moved by Plant Operations electrician to allow proper clearance from sprinkler heads on the date listed. 3. Plans will be developed and submitted to state for review to provide proper sprinkler coverage of skylight ceilings in atrium. Due to contractor prior commitments we will not be able to complete this item by 6/17/06.	~~10/31/06~~ 6/17/06 5/24/06 ~~11/15/06~~ 6/17/06

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K 056	Continued From page 8 the Code. The nearest sprinklers were more than three feet below the skylight ceiling.	K 056	In order to complete this K-tag we will need a time waiver based on the following milestones. Plan development will be completed by 7/31/06. Plans will be submitted to state for review and approval 8/1/06. Contractor will install additional heads according to plans and be completed by 11/15/06.	
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, the facility failed to maintain the installed sprinkler system in accordance with NFPA 25 Section 2-4.1.4. The finding was: 1. On 05/03/06 at 1 PM, the sprinkler cabinet lacked two spare pendent sidewall sprinkler heads to replace the heads installed in the hydro-therapy area.	K062	Required automatic sprinkler systems are continuously maintained in reliable operating condition. 1. Spare pendent sidewall sprinkler heads have been ordered through outside contractor and will be placed in the sprinkler cabinet upon arrival. They will be in the cabinet by the date listed. Will be monitored by plant operations staff and outside contractor during routine inspections.	6/17/06
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, the facility failed to maintain 1 of 1 K-type portable fire extinguishers	K064	Portable fire extinguishers are provided in all healthcare occupancies in accordance with NFPA 10. 1. We ordered and mounted an additional K type extinguisher in the area of the bakery cooking range top. This was completed on the date listed. 2. Upon further inspection the mentioned extinguisher was hydrostatic tested in August of 2002 and sticker was placed on back of extinguisher. This will be monitored by plant operations staff during hazardous surveillance rounds.	5/24/06

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K 064	Continued From page 9 in accordance with NFPA 10 Section 3-7.2 and Table 5-2 respectively. The findings were. 1. On 05/03/06 at 2:56 PM, the K-type fire extinguisher in the kitchen was located more than the allowed 30 feet from the Bakery cooking range top. The K-type extinguisher was 40 feet from the Bakery range. 2. On 05/03/06 at 2:54 PM, the K-type portable fire extinguisher in the kitchen was manufactured in 1998 and it had not received a five year hydrostatic test as required by the Code.	K 064		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide an oxygen store in accordance with NFPA 99 Section 4-3.1.1.2 (c). The finding was: 1. On 05/03/06 at 9:27 AM, the oxygen store room lacked any type of dedicated ventilation to the outside.	K 076	Location for supply systems of greater than 3,000 cu.ft. are vented to the outside. 1. A vent panel of 80 sq. inches was installed on the exterior door to the oxygen storage room, by plant operations staff on the date listed. This will be monitored by plant operations staff during hazardous surveillance rounds.	5/24/06

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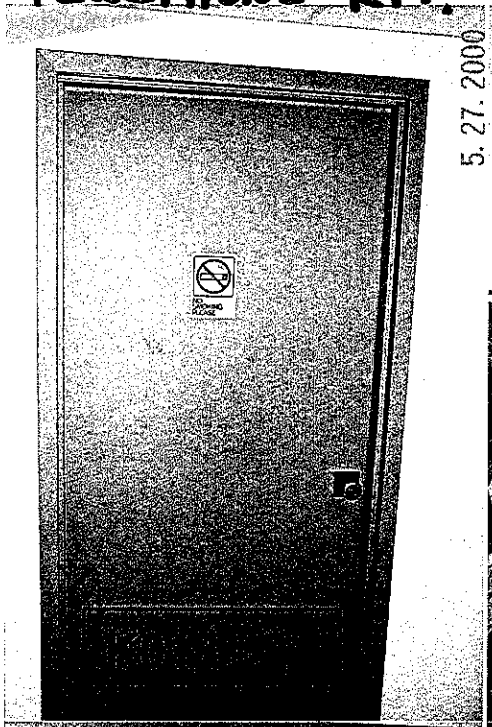
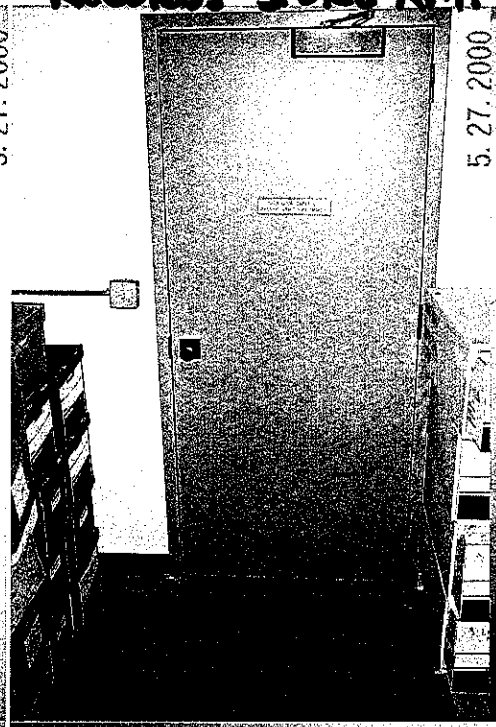
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 110-26. The findings were: 1. On 05/03/06 between 11:30 AM and 1 PM, the following locations had stored items closer than the allowed three feet from electrical panels: a. The second floor service elevator landing b. The basement data/telephone room	K 147	A minimum of 3 foot clearance will be maintained on all electrical panels. 1. The gurney was moved to a new location on 5/4/06. 2. Items were reorganized and moved from in front of electrical panel on or before 5/17/06. This will continued to be monitored by plant operations staff during hazardous surveillance rounds.	5/17/06

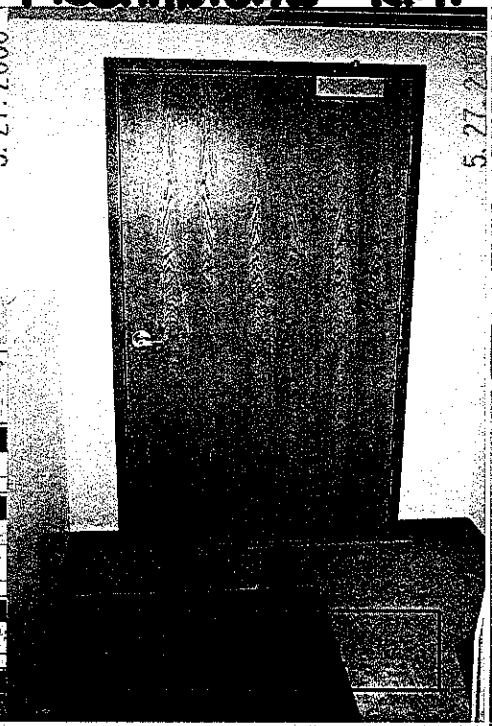
BASEMENT DATA/ TELEPHONE RM.



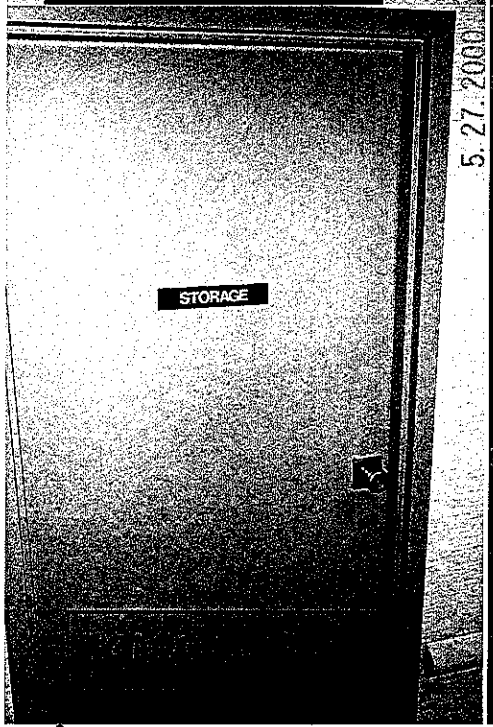
BASEMENT MED. RECORDS STORE RM.



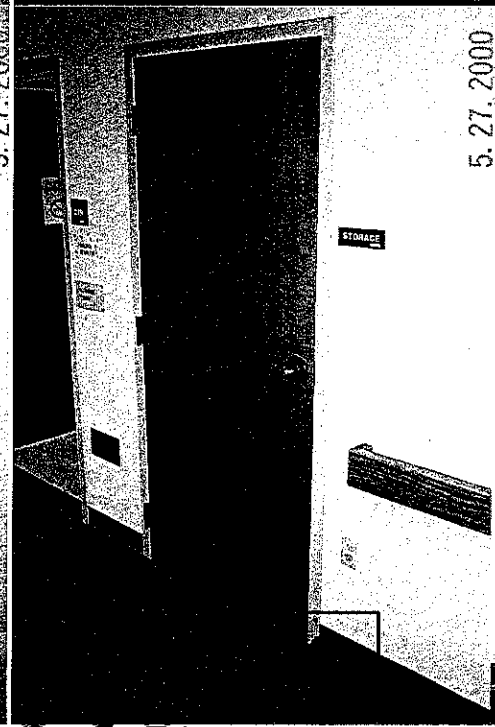
BASEMENT P.T. MECHANICAL RM.



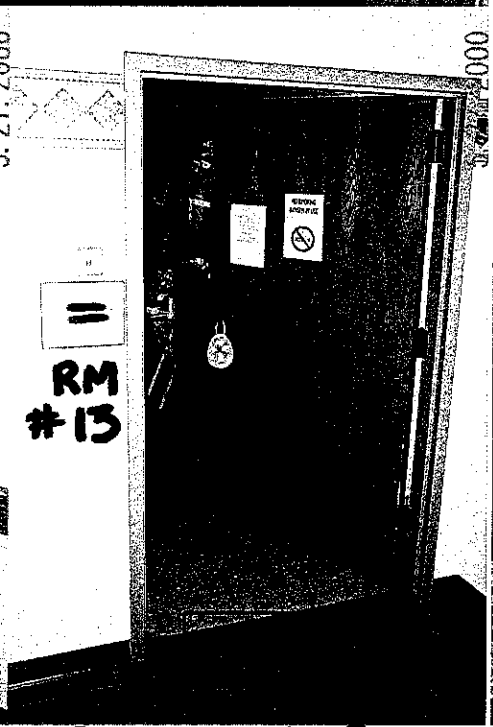
Lobby store room



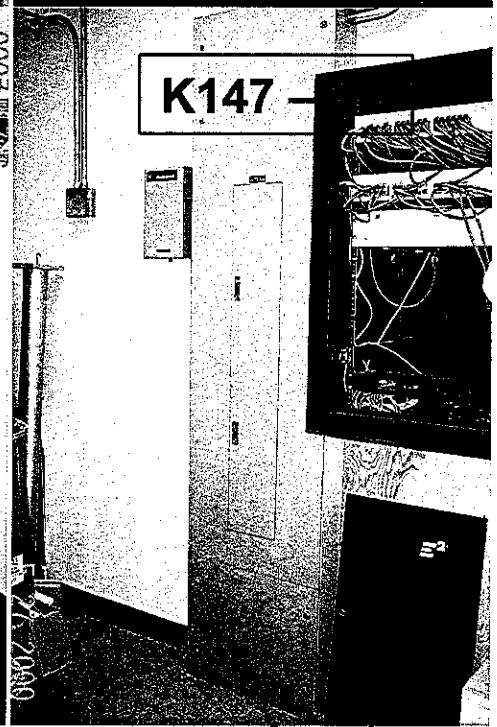
1st Floor clean utility Rm. North



2nd Floor Store Rm. near #219



Resident Room #13



Basement data/ telephone room

Room # 235

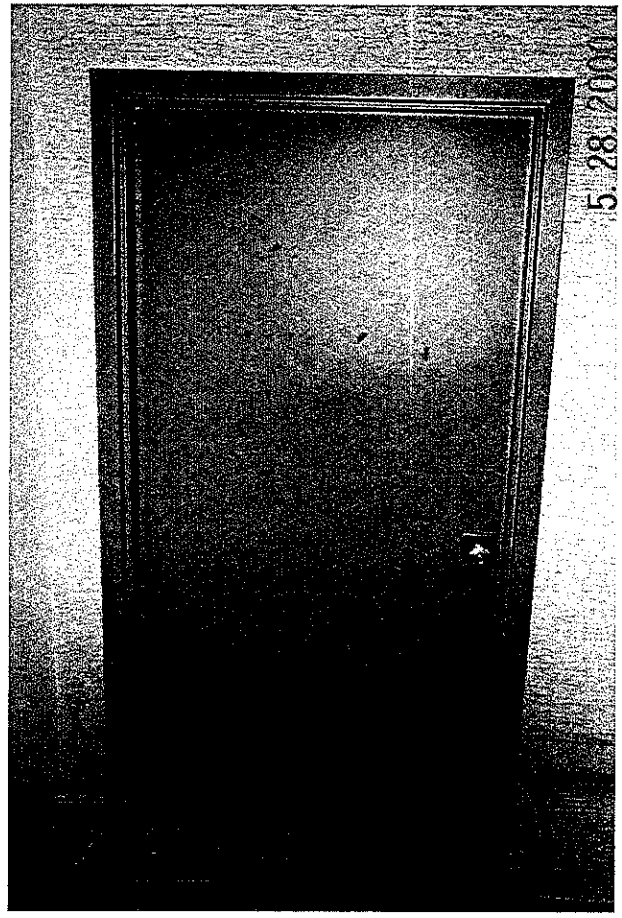
PANTRY Light moved away from sprinkler head

Ventilation panel on Oxygen storage room

2nd floor service elevator landing

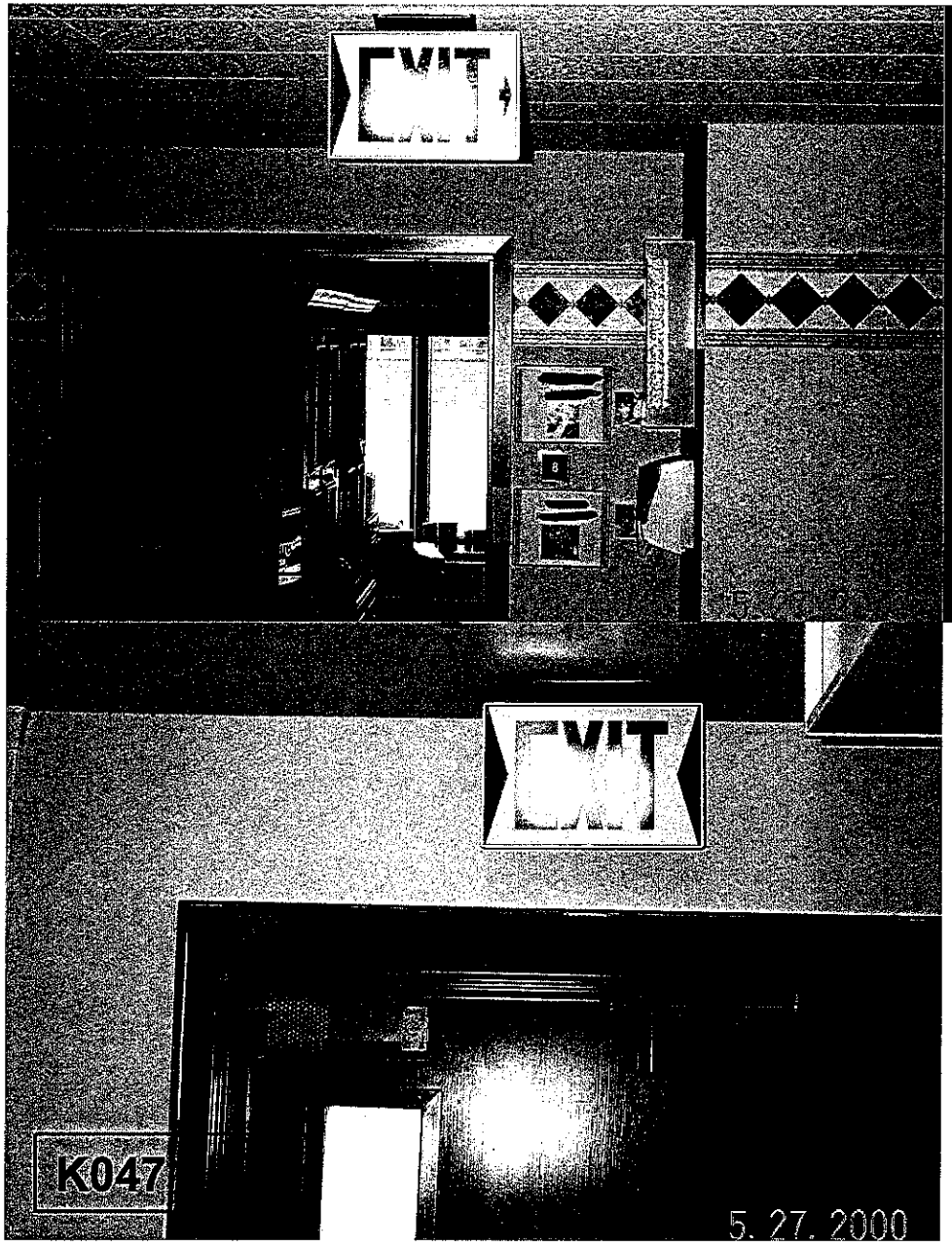
pg 14

Hallway near room #2 East

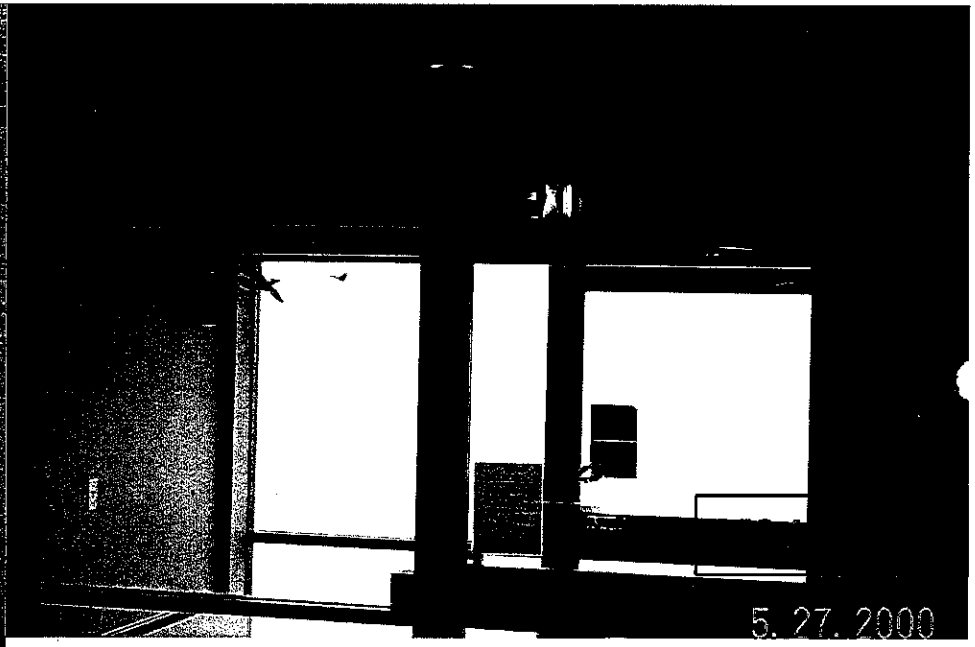


K029-2b
South wing housekeeping storage room

Near resident room #8



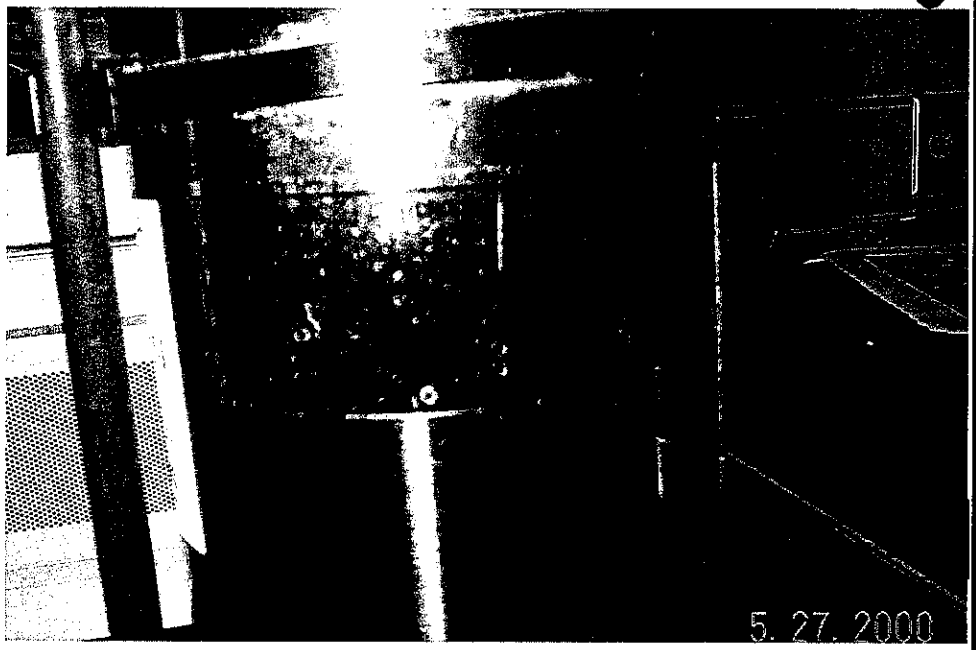
Near resident room #28

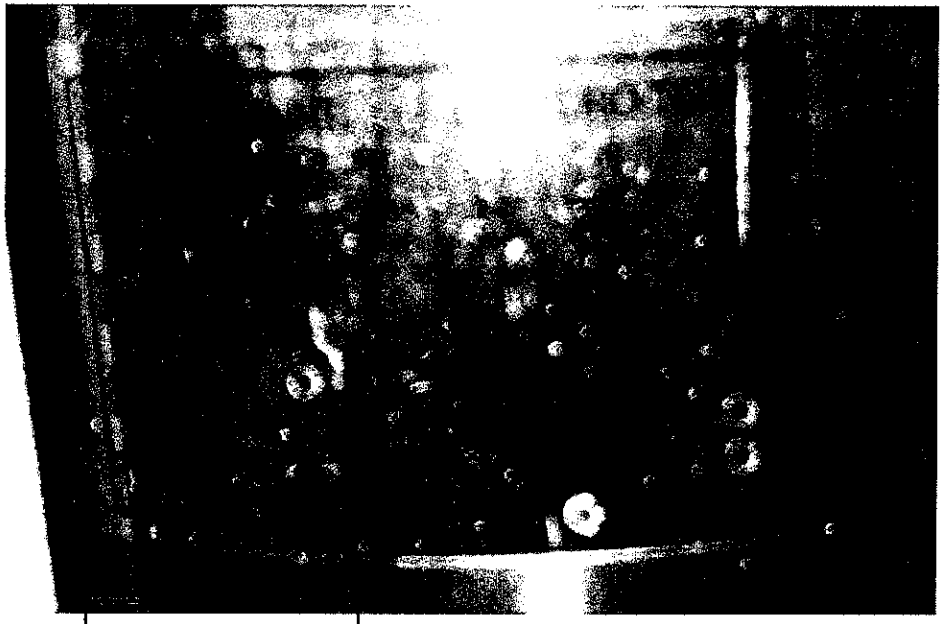


Ground level in the north stair tower

pg 16

Tag on back of fire extinguisher in Kitchen for hydrostatic testing





K064 – 2

Added fire extinguisher in the bakery cooking area