STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 786, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) construction built in 1978 and 1983. The building was equipped with a supervised automatic wet sprinkler system and fire alarm system.	K 000	PoC Accepted on 9/04/07 w/ Deborah Wood, NHA. • The facility will construct a corridor through the dining room, but will request a waiver to allow time for this construction to occur. The code states that a door from one occupancy level into another must open onto a corridor, this construction will satisfy this code requirement. • The Administrator will be responsible for ensuring that the construction is completed in a timely manner and that it is applicable to the code. The Maintenance Director will be responsible for identifying other violations of such code throughout the facility and will report those directly to the Administrator and provide updates at the quarterly Quality Assessment and Assurance (QAA) meeting.	~~2/6/08~~ 8/30/07
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure 1 of 1 fire wall only had communicating openings into corridors. Findings were: Observation on 8/07/07 at 12:20 PM revealed there was an access door in the fire wall between the kitchen and dining room in the apartment building.	K 011		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4,	K 012	Maintenance shall ensure that all smoke and fire barriers do not have any holes or other open penetrations, and shall ensure that this standard is met by:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah J. Wood	Administrator	8/30/07

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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SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

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K 012	Continued From page 1 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure there were no unsealed penetrations in 1 of 5 smoke compartments. The findings were: Observation on 8/07/07 at 9:39 AM revealed the ceiling in the north mechanical room had a 3-inch unsealed pipe penetration above the water heater.	K 012	• Maintenance shall remove debris from around pipe penetration • Maintenance Director shall obtain Fire Caulking and seal penetration with same. • Maintenance Director shall inspect facility monthly to discover and then repair any future penetrations within smoke compartments. • Findings from the inspection shall be reported to the Administrator, and the Maintenance Director shall review the findings with the Quality Assurance Committee quarterly.	8/29/07
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 maintain 1 of 2 fire barrier doors. The findings were: Observation on 8/07/07 at 12:42 PM revealed 1 of 2 cross corridor fire barrier doors near the kitchen did not fully latch into the frame.	K 027	Maintenance shall ensure that the smoke barrier doors shall meet this standard by: • The Maintenance Director will adjust door latches on door near kitchen so that they lock in a positive manner. • The Maintenance Director will inspect on a monthly basis, and • Findings from the inspection shall be reported to the Administrator, and the Maintenance Director shall review the findings with the Quality Assurance Committee quarterly.	8/21/07
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029 SS=D	Continued From page 2 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 observation and staff interview, the facility did not ensure storage of flammables in 1 of 8 locations only occurred in rooms with required smoke resistant assemblies. Findings were: Observation on 8/7/07 at 9:52 AM revealed 12 cardboard boxes containing disposable briefs were stored in an empty resident room (#11). The structure of the room and the corridor door did not meet minimum requirements for fire resistance as required by the Code. Interview with the administrator on 8/7/07 at 2 PM revealed the director of nursing had ordered a larger quantity of disposable briefs than usual, and the excess could not be stored in the existing storage location..	K 029	• Sublette Center staff moved boxes out of room 11, stocked patient rooms, and put the remainder in the nurses store room. • The Director of Nursing (D.O.N.) will ensure that supplies are purchased in manageable numbers and stored properly. • Environmental Services Director will do weekly checks of all rooms and report to the D.O.N. and Administrator. Results of weekly checks will also be discussed at Q.A.A. Meetings.	8/8/07
K 050 SS=F	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	K 050	• The Environmental Services Director will perform more frequent	9/8/07

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9/04/07

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K 050	Continued From page 3 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, staff interview, and observation, the facility failed to ensure fire drills were conducted at unanticipated times or that the staff were familiar with actions required under varied simulated fire conditions. Findings were: 1. Review of the fire drill records revealed the drills conducted on the day shift had not been at unexpected times. All of the drills over the past year had occurred between 2:30 PM and 3:30 PM. 2. Interview with the maintenance director on 8.07/07 at 9:30 AM confirmed the fire drill records were accurate and the documented times were correct. 3. Observation on 8/07/07 at 1:36 PM revealed the first responder to the fire drill did not close the "fire" room door. The corridor door to the "fire" room was not closed at any time during the fire drill. The first responder announced code Red over the intercom system before activating the fire alarm system as indicated in the facilities fire policy.	K 050	and less predictable drills, alarms may sound more often. • More inservices will be given by Environmental Services and employees will be tested for understanding of best procedures. Drills will be reviewed with participating staff to correct errors in performance of the drill. • The Environmental Services Director will perform weekly spot inservices for a period of 90 days and will monitor effectiveness through staff discussions and report results to the Administrator and the Q.A.A. committee.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056	The facility will ensure that all areas of the building are sprinkled in accordance with	9/22/07

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K 056	Continued From page 4 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 observation the facility did not ensure all sprinklers in 2 of 5 smoke compartments were installed as required. Findings were: 1. Observation on 8/7/07 at 9:42 AM revealed the partition wall between the kitchenette that was off the entry into the Howard Smith dining room ended 8 inches from the ceiling. As a result, the spray pattern from the sprinkler in the kitchenette was obstructed and would not protect the entry area. 2. Observation on 8/7/07 at 10:20 AM revealed 1 ceiling mounted pendant sprinkler head in the soiled utility room was installed less than two inches from the wall.	K 056	NFPA 13 as evidenced by: • The Administrator will hire a sprinkler contractor to move the sprinkler in the Howard Smith kitchenette to ensure that the entry area is adequately sprinkled and the sprinkler in the soiled linen room will be moved an appropriate distance from the wall to ensure the soiled linen room is also adequately sprinkled. • The Maintenance Director will monitor practice by performing weekly checks of sprinklers to determine if sprinklers do not comply with NFPA 13 and will follow up after construction to ensure sprinklers are appropriate distances from walls and that sprinkler spray is not obstructed. • The Maintenance Director will report all findings immediately to the Administrator and review the status of the sprinkler systems compliance at the quarterly QAA meetings.	
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	K 062	Maintenance shall ensure that the fire sprinkler systems are continuously maintained and shall meet this standard by:	8/22/07

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K 062	Continued From page 5 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to test and maintain 2 of 3 sprinkler system components. The findings were: 1. Review of the fire sprinkler testing records revealed the supervisory signal device had not been tested in the last year. 2. Review of the fire sprinkler testing records revealed the main drain test had not been performed in the past year. 3 Interview with the maintenance director on 8/07/07 at 9:30 AM revealed he had not tested the supervisory signal or main drain at any time over the past year. He further reported that he did not know how to test these devices.	K 062	• The Maintenance Director shall become knowledgeable with the testing procedures of the fire sprinkler system. • The Maintenance Director shall test the fire sprinkler systems on a monthly QUARTERLY basis. • The Maintenance Director shall maintain testing records. • Findings from the monthly tests of the fire sprinkler system shall be reported to the Administrator, and the Maintenance Director shall review the testing results with the Quality Assurance Committee quarterly.	
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not 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	K 075	The facility will ensure that not more than 32 gal receptacles are placed within 8 feet of one another and no more than 32 gal is present in a 64 square foot area as evidenced by: • The Environmental Services Director will check all receptacles to ensure that receptacles present are no larger than 32 gal and that bags ordered for receptacles are no larger than 32 gal. • The Environmental Services Director will perform weekly walk thrus to inspect receptacles to monitor and ensure that receptacles larger than 32 gal are not used or inappropriately	8/30/07

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K 075	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations the facility failed to limit the soiled linen or trash collection receptacles in 1 of 5 smoke compartments to one per 64 square feet. Findings were: Observation on 8/07/07 at 10:15 AM revealed two soiled utility barrels were stored in the restroom of resident room #5. The restroom's area was less than 64 sq. ft.	K 075	placed in proximity to one another. Rooms where more than one receptacle are needed will have signs marking appropriate placement of receptacles. • The Environmental Services Director will report findings from weekly checks to the Administrator and will summarize findings for the Q.A.A. Meetings.	
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 record review and staff interview, the facility failed to collect 7 of 12 transfer time for the installed emergency generator in the past year. The findings were: 1. Review of the emergency generator testing records revealed the transfer times from one energy source to another had not been collected for the months of August, September, October, November and December, 2006 as well as April and July, 2007. 2. Interview with the maintenance director on 8/07/07 at 9:30 AM confirmed the transfer times had not been collected for the mentioned months.	K 144	Maintenance shall ensure that the emergency generator system is continuously maintained and shall meet this standard by: • The Maintenance Director shall become knowledgeable with the testing procedures of the emergency power generation system. • The Maintenance Director shall test the emergency power generation on a weekly basis, with under load once each month. • The Maintenance Director shall maintain accurate testing records, and • Findings from the monthly tests of the emergency power generation system shall be reported to the Administrator, and the Maintenance Director shall review the testing results with the Quality Assurance Committee quarterly.	8/8/07

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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 observation the facility failed to ensure that temporary wiring was not used in place of fixed permanent wiring in 1 of 6 smoke compartments. The findings were: Observation on 8/07/07 at 9:48 AM revealed a radio was plugged into an extension cord in the Howard Smith dining room.	K 147	The facility will ensure compliance with NFPA 70 as evidenced by: • The extension cord plugged into the radio in the Howard Smith dining room will be removed and an approved surge protector will be used. • The Maintenance Director will perform weekly inspections of rooms to monitor for use of extension cords and to ensure that extension cords are removed. • The Maintenance Director will report inspection findings to the Administrator and summarize findings each quarter for the QAA committee.	8/22/07

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

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	535017	A. BUILDING 02 - APARTMENT BUILDING B. WING _____	08/07/2007

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Apartment Buildings of the National Fire Protection Association. The facility was a Non-sprinklered single story building of Type V (111) construction built in 1978. The building was equipped with a fire alarm system. Interview with the administrator on 8/07/07 at 8 AM revealed the dining room in the apartment building was routinely used by the ambulatory residents in the nursing home. As a result, the smoke compartment in which the dining room was located was surveyed under the Existing Apartment Building chapter of the Life Safety Code, 2000 edition.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation the facility failed to seal penetrations in 1 of 2 fire barrier walls. The findings were:	K 011	Maintenance shall ensure that all smoke and fire barriers do not have any holes or other open penetrations, and shall ensure that this standard is met by: • Maintenance Director will fill the unsealed cable penetration in the fire wall separating the apartment building with Fire Caulking. • Maintenance Director shall inspect fire walls monthly and following any repairs or construction to discover and then repair any future penetrations with Fire Caulking in smoke compartments. • Maintenance Director shall report all findings to the Administrator and review	9/7/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J. Wood
TITLE: Administrator
(X6) DATE: 8/30/07

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K 011	Continued From page 1 Observation on 8/07/07 at 12:36 PM revealed the 2-hour fire barrier wall separating the apartment building into two compartments had 1 unsealed cable penetration.	K 011	the inspection report with the Quality Assurance Committee.	
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 observation the facility failed to maintain corridor doors as required in 1 of 1 smoke compartment. The findings were: Observations on 8/07/07 between 11:30 AM and 12 PM revealed the following corridor locations had doors that were not equipped with self-closing devices: a. Apartment #304.	K 018	Maintenance shall ensure that all doors that open onto exit access corridors shall meet this standard by: • Maintenance shall install a self-closing device on the following apartment doors: #304, #306, #309, #315, and #318. • Maintenance shall inspect all corridor doors each quarter to ensure that all self closing devices are attached and functional. • Findings from the inspection shall be reported to the Administrator, and the Maintenance Director shall review the findings with the Quality Assurance Committee quarterly.	9/22/07

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K 018	Continued From page 2 b. Apartment #306. c. Apartment #309. d. Apartment #315. e. Apartment #318. NFPA 101 Section 31.3.6.3 states "Doors that open onto exit access corridors shall be self-closing and self-latching."	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 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 observation the facility failed to separate 2 of 4 hazardous areas from other spaces by 1-hour fire rated assemblies. The findings were: 1. Observation on 8/07/07 between 11:47 AM revealed the corridor door to the laundry room was equipped with a self-closing device; however, the door did not close with the activation of the fire alarm system. The self-closing device was noted to be equipped with a hold-open arm. 2. Observation on 8/07/07 at 11:54 AM revealed	K 029	The facility will ensure that appropriate spaces are separated by smoke resisting partitions and doors as evidenced by: • The Environmental Services Director will remove the hold-open arm from the laundry room door and the housekeeping storeroom door will be equipped with a self-closing device. • Laundry door changes may make it difficult for residents to access the laundry room with arms full. A hold-open device wired into the building alarm system may be installed at a future date. • Environmental Services Director will perform quarterly inspections to monitor and ensure that self-closing devices are in place and functional on all smoke resisting partitions and doors. • Environmental Services Director will report inspection findings to the Administrator and summarize findings for the QAA committee.	9/7/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 02 - APARTMENT BUILDING B. WING _____	08/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 029	Continued From page 3 the corridor door to the housekeeping storeroom was not equipped with a self-closing device.	K 029		
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 observation the facility failed to ensure temporary wiring did not replace fixed permanent wiring in 1 of 2 smoke compartments. The findings were: Observation on 8/07/07 between 9:30 AM and 12 PM revealed the following electrical concerns: a. Resident room #308 in the apartment building had a lamp plugged into a 3-way adapter. b. Resident room #318 in the apartment building had a heating pad and lamp plugged into an extension cord.	K 147	The facility will ensure compliance with NFPA 70 as evidenced by: • The three way adapter being used in room #308 will be removed by the Environmental Services Director and a power strip allowed to be put in its place. The extension cord plugged in for room #318 will be removed and a power strip will be allowed to be put in its place. • The Environmental Services Director and housekeeping staff will perform weekly inspections of rooms to monitor for use of extension cords and three way adapters and to ensure that neither are used and that other safe alternatives are suggested. Housekeeping staff will be instructed to look for such violations of NFPA 70. • The Environmental Services Director will report inspection findings to the Administrator and summarize findings each quarter for the QAA committee.	8/30/07