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

Printed: 09/29/2008
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
	535049	A. BUILDING 01 - LIFE CARE CENTER OF CA B. WING _____	08/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR CASPER, WY 82601

(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 K7 SURVEY UNDER : EXISTING K8 NF TYPE OF STRUCTURE: SINGLE STRUCTURE, TYPE V (III), FULLY SPRINKLERED. THE FACILITY HAD A BED CAPACITY OF 120 AT THE TIME OF THE SURVEY. DURING A ROUTINE RECERTIFICATION SURVEY CONDUCTED ON AUGUST 19, 2008, THE FACILITY WAS FOUND OUT OF COMPLIANCE WITH 42 CFR 483.70(a), AS EVIDENCED BY THE FOLLOWING DEFICIENCIES OF THE NFPA 101 LIFE SAFETY CODE (LSC) AND THE CODES REFERENCED BY THE LSC. THE FOLLOWING WERE OBSERVED BY THE LIFE SAFETY CODE SURVEYOR WHILE ACCOMPANIED BY THE FACILITY MAINTENANCE SUPERVISOR. THE DEFICIENCIES NOTED WERE AS FOLLOWS:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	K 025 The facility will ensure maintenance of smoke barriers in a construction that provides at least a one-half hour fire resistance rating. This will be accomplished: A. The open areas of penetration around either side of the wall in the west corridor, above the double doors near the assisted dining room where electrical conduit and three communications lines will be sealed. The open area around the sprinkler pipe located between the assisted dining room and the dish washing room will be sealed The open area around the electrical conduit located above the double door between the main dining room and the kitchen will be sealed. The open ends on either side of the two wire conduits located across the west corridor will be sealed. The open ends on either side of the of the four conduits in the attic barrier wall near	10/14/08

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

x [signature] x Executive Director x 9-22-08

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 025	Continued From page 1 This Standard is not met as evidenced by: Based on observation and staff interview it was determined that the facility did not maintain smoke barriers of a construction that provided at least a one-half hour fire resistance rating. The findings include: Observation was made of smoke barrier walls in the facility during a tour with the facility maintenance supervisor on 8/19/08. The maintenance supervisor confirmed the unsealed penetrations at the time of the observations. Penetrations were observed in the following smoke barrier walls: 1. Observation of the barrier wall in the west corridor above the double doors near the assisted dining room found an electrical conduit and three communications lines that penetrated the barrier wall. The open areas around these penetrations were not sealed on either side of the wall. 2. Observation of the barrier wall between the assisted dining room and the dish washing room found a sprinkler pipe that penetrated the wall. The open area around the pipe was not sealed. 3. Observation of the barrier wall above the double door between the main dining room and the kitchen found an electrical conduit that penetrated the wall. The open area around the electrical conduit was not sealed. 4. Observation in the attic of the barrier wall across the west corridor found two wire conduits that penetrated the wall. The open ends of both conduits were not sealed on either side of the	K 025	resident rooms 102 and 106 will be sealed on either side. The open ends of three wire conduits that penetrated the wall in the attic barrier near resident rooms 113 and 116 will be sealed on either side. Open areas around the two wires conduits in the attic barrier wall near resident rooms 214 and 219 will be sealed on both sides. The open area around the sprinkler pipe will be sealed. Open ends of four wire conduits in the attic of the barrier wall near resident rooms 225 and 229 will be sealed on both sides. B) All areas of the building will be inspected and repairs made assuring that smoke barriers of a construction that provides at least a one-half hour fire resistance rating are maintained and repairs made as needed. C) The maintenance director will inspect areas of the facility looking for unsealed penetrations and make appropriate repairs as needed.	

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K 025	Continued From page 2 wall. 5. Observation in the attic of the barrier wall near resident rooms 102 and 108 found four wire conduits that penetrated the wall. The open ends of all four of the conduits were not sealed on either side of the wall. 6. Observation in the attic of the barrier wall near resident rooms 113 and 116 found three wire conduits that penetrated the wall. The open ends of all three conduits were not sealed on either side of the wall. 7. Observation in the attic of the barrier wall near resident rooms 214 and 219 found two wire conduits that penetrated the wall. The open areas around both conduits were not sealed on either side of the wall. The wall was also penetrated by a sprinkler pipe that had been previously sealed, but the sealant had come loose from the open area around the pipe and did not make an effective seal. 8. Observation in the attic of the barrier wall near resident rooms 225 and 229 found four wire conduits that penetrated the wall. The open ends of all four of the conduits were not sealed on either side of the wall.	K 025	D) A quality monitoring tool will be developed to track unsealed penetrations and their repairs. The tracking will be performed quarterly and reported to the facility's performance improvement committee on a quarterly basis by the maintenance director.	
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	K 027		

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K 027	Continued From page 3 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 and staff interview it was determined that the facility failed to maintain smoke barrier doors to resist the passage of smoke in a smoke barrier wall. The findings include: Observation was made of the smoke barrier doors near resident room 215 during testing of the fire alarm system. The observation was made with the facility maintenance supervisor. One of the double doors remained open, even though the magnetic hold device for the door had been demagnetized by the activation of the fire alarm system. Upon further investigation it was observed that the bottom of the door was wedged against the floor and would not close unless forced by hand. The maintenance supervisor stated at the time of the observation that the door would need adjustment to prevent it from being held open.	K 027	The facility will ensure that smoke barrier doors will resist the passage of smoke in a smoke barrier wall. This will be accomplished by: A) The smoke barrier doors near resident room 215 will be adjusted so that the door would close automatically when the magnetic hold device for the door is demagnetized by activation of the fire alarm system. B) All smoke barrier doors will be inspected to ensure that they close automatically when the magnetic hold device for the doors is demagnetized by activating the fire alarm system. C&D) A quality monitoring tool will be developed to track the automatic closure of all smoke barrier doors when the magnetic hold device for the door has been demagnetized by activating the fire alarm system. The monitoring will be performed monthly and reported quarterly to the facility's performance improvement committee by the maintenance director.	10/14/08
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and staff interview it was found that the facility failed maintain exit access so that exits are readily accessible at all times.	K 038		10/14/08

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K 038	Continued From page 4 The findings include: 1. Observation was made of the secured double doorway between the secured unit and the northeast nurse ' s station during fire alarm testing on 8/19/08. The double doorway was secured through use of a magnetic lock. The locking mechanism was controlled by a numeric code key pad located on both sides of the double doors. At the time of the observation the maintenance supervisor stated that the door should open when the bar on the door was pushed in and held. Testing of the door in this manner found that the door would not open and could only be opened when the numeric key pad was used.	K 038	The facility will ensure that exit access is arranged so that exits are readily accessible at all time. This will be accomplished by: A) The double doorway to the secured unit will be repaired so that when the fire alarm system is activated the magnetic locking system releases and the doors are unlocked. B) N/A there are no other magnetic locking systems in the facility.	10/10/08
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This Standard is not met as evidenced by: Based on observation, record review and staff interview it was found that the facility did not have a plan in place to prevent re-entry into a fire zone that was involved in an evacuation during a fire. Record review found that the posted fire plan was incorrect in identifying appropriate fire exits from the facility. The findings include: 1. Observation found that the facility maintained a courtyard for use by residents of the secured unit. The courtyard was only accessible by one doorway from the secure unit day room. The courtyard was enclosed by wooden stockade type fence. Egress from the courtyard could only be	K 048	C & D) A quality monitoring tool will be developed to monitor the automatic unlocking of the magnetic locking door to the secured unit when the fire alarm system is activated. The monitor will be tracked monthly and reported quarterly to the facility's performance improvement committee by the maintenance director.	

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K 048	Continued From page 5 made through a single gate. The gate was secured by three bolt type locks. None of the locks were accessible from inside of the courtyard. The top bolt lock was secured with a keyed padlock preventing it from being opened unless a key was used. At the time of the observation of the courtyard the maintenance supervisor stated that he was the only person that had a key to the gate. The supervisor confirmed that if he was not present at the facility no other staff would be able to open the gate should the courtyard need to be evacuated and passage back into the facility was prevented because the fire zone of the secure unit was involved in a fire evacuation. Record review found that the facility fire plan made no provisions for how the courtyard would be evacuated in the event that re-entry into the facility could not be made. 2. Review of the posted fire plan for identifying appropriate fire exits identified the exit from a day room of the secure unit into the secure unit courtyard as being a fire exit. The door was physically marked as NOT being a fire exit. The maintenance supervisor confirmed at the time of the review of the posted fire plan that the passage way from the secure unit day room to the courtyard was purposely identified as not being a fire exit and should not have been identified on the fire plan as being an exit.	K 048	The facility will ensure that there is a written plan for the protection of all patients and for their evacuation in the event of emergency. This will be accomplished by: A) The facility's fire plan will be updated to include how the Special Care Unit's courtyard will be evacuated in case of a fire. The three bolt type locks on the outside of the gate will be removed and a combination lock will be installed on the inside of the gate. The nursing staff will be made aware of the lock's numerical combination. The posted fire plan will be updated to show that the door exiting into the SCU courtyard is not a fire exit. B) N/A. There are no other courtyards with gate locks or courtyards marked as fire exits. C&D) A quality monitoring tool will be developed to assure the combination lock on the SCU courtyard gate and to assure only the updated evacuation floor plans showing that the door from SCU into the courtyard is not identified as an	10/6/08
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	K 147		

K048

exit. The monitor will be performed two times a year and reported semi-annually to the facility's quality monitoring committee by the facility's maintenance director.

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K 147	Continued From page 6 This Standard is not met as evidenced by: Based on observation it was found that the facility failed to prohibit the use of power strips as a substitute for adequate wiring for vital health care equipment. The findings include: 1. A tour of the facility was made with the facility maintenance supervisor on 8/19/08. During this tour observation was made of resident room 206. The use of pump for enteral feeding was observed to be plugged into a power strip rather than directly into an electrical outlet.	K 147	The facility will ensure that electrical wiring and equipment is in accordance with NVPA 70. This will be accomplished by: A) The enteral feeding pump for the resident in room 206 was unplugged from the power strip and plugged into the emergency outlet in the room. B) All vital health care equipment will plugged directly into an electrical outlet in the room. C & D) A quality monitoring tool will be developed to monitor the compliance of plugging all vital health care equipment directly into electrical outlets and not using power strips. The results of the monitoring will be reported monthly to the facility's performance improvement committee by the maintenance supervisor. Addendum: The POC for the state survey conducted on 7/17/08 has been completed. The power strips that were being used in the shower rooms have been removed.	10/14/08

Life Care Center of Casper

4041 South Poplar Street/Casper, Wyoming 82601/(307) 266-0000/FAX (307) 234-8934

accepted POC per Robert Castle RW 9/29/08

FAX

To: Wendy Karpowicz From: Jean Mahaffey

Fax: 303-860-5862 Pages: 10

Phone: Date: 9/22/08

Re: Life Safety Survey CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Please call if you have questions

Comments

A Life Care Centers of America Facility

Life Care Center of Casper

4041 South Poplar Street/Casper, Wyoming 82601/(307) 266-0000/FAX (307) 234-8934

SEP 29 2008

September 22, 2008

Wendy Karpowicz
Centers for Medicare and Medicaid Services
Survey and Certification Branch, Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202-4967

Dear Ms Karpowicz:

On August 19, 2008, a Life Safety Code survey was conducted at our facility by the Denver Regional Office surveyor. As a result of the survey, alleged deficiencies were identified.

Attached please find the completed CMS-2567 form. Please consider this letter and the Plan of Correction to be the facility's credible allegation of compliance. The facility will achieve substantial compliance with the applicable certification requirements on or before October 16, 2008.

Please notify me immediately if you do not find the Plan of Correction to be written as credible evidence of the facility's substantial compliance with the applicable requirements as of this date.

This letter is also a request for a re-survey, if one is necessary, to verify that the facility achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction and the credible allegation of compliance.

We always learn from each and every survey and would like to acknowledge the professionalism and information provided by Robert Casteel during this survey.

Please feel free to call me if you have any questions.

Sincerely,

Sara Delahoyde, Executive Director