| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535049 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/15/2010 |

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

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| K 000 | INITIAL COMMENTS<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this 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 (NFPA). | K 000 | | |
| K 025 SS=E | The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and with an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 116 residents.<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure smoke barrier walls located between 4 of 7 smoke compartments were smoke resistant. The findings were: | K 025 | The facility will ensure smoke barriers are constructed to provide at least a one half-hour fire resistance rating in accordance with 8.3.<br><br>A) The penetrations in attic smoke barrier walls above the 200 and 100 halls were repaired on 1/12/11 using a fire resistant caulk and appropriate width drywall.<br><br>B) The maintenance director will observe smoke barriers to ensure there are no penetrations. Penetrations found will be immediately repaired with a fire resistant caulk.<br><br>C) The maintenance director will audit for penetrations and report his findings at the monthly Performance Improvement meeting. This will occur for 3 months or until ongoing compliance. | 1/12/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/13/11

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.

POC Accepted w/ Tim Hazen, ED, on 1/21/11

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| K 025 | Continued From page 1<br>Observation of the attic smoke barrier walls on 12/15/10 between 1 PM and 2 PM showed the walls above the 200 hall and 100 hall contained several unsealed penetrations. The largest penetration was 6 x10 inches. At 1:45 PM the maintenance director reported the smoke barrier walls were not routinely inspected. | K 025 | | |
| ~~K 029~~<br>SS=E | ~~NFPA 101 LIFE SAFETY CODE STANDARD~~<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 7 smoke compartments. The findings were:<br><br>Observation of the kitchen dry storeroom on 12/15/10 at 1:17 PM showed more than 20 boxes of food products were being stored in cardboard boxes. Further review showed the door was not equipped with an automatic closing device. At the time of observation the maintenance director reported he was not aware of the separation requirement. | ~~K 029~~ | The facility will ensure one-hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1.<br><br>A) An automatic closing device was placed on the kitchen dry storage room door on 1/12/11.<br><br>B) The facility doors were audited for fire construction during survey. No other problems were identified.<br><br>C) The findings of the audit will be presented at Performance Improvement. | 1/12/11 |
| K 038 | NFPA 101 LIFE SAFETY CODE STANDARD | K 038 | | |

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| K 038 SS=F | Continued From page 2<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | K 038 | The facility will ensure exit access is arranged so that all exits are readily accessible at all times accordance with section 7.1<br><br>A) "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS" signs will be placed on all exit doors with magnetic locks.<br><br>B) The maintenance director will observe annually to ensure signs are present on all exit doors with magnetic locks.<br><br>C) The maintenance director will report his findings to the monthly Performance Improvement meeting. This will occur for a period of 3 months or until ongoing compliance. | 1/14/11 |
| | This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure 10 of 11 exit doors were provided with delayed egress unlocking instructions. The findings were:<br><br>Observation of the southwest exterior exit door on 12/15/10 at 9:47 AM showed the door was equipped with a delayed egress magnet locking system. Further review showed the door was not provided with a sign reading "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS". At the time of observation the maintenance director reported 10 of 11 exits were equipped with delayed egress locks and none of them were provided with the required signs. Furthermore, he reported the magnetic locks release with the activation of the fire alarm system and lose of facility power. The magnetic locks released with the activation of the fire alarm system during the fire drill at 3:20 PM. Interview with two certified nurses assistants, staffing different sections of the building between 10 AM and 12 PM confirmed they both knew the combination to the use on the electronic key pad to release the magnetic locks. | | | |
| K 052 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system required for life safety is installed, tested, and maintained in accordance | K 052 | | |

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| K 052 | Continued From page 3<br>with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 | K 052 | The facility will ensure the fire alarm system is installed, tested and maintained in accordance with NFPA 70.<br><br>A) The facility fire system testing company came to the facility on 1/10/11 and identified 110 detectors and 54 heat detectors that required inspection.<br><br>B) The maintenance director will audit testing results after inspections to ensure all detectors are included.<br><br>C) The maintenance director will report his findings to the monthly Performance Improvement meeting. This will occur for a period of 3 months or until ongoing compliance. | 1/15/11 |
| | This STANDARD is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to ensure fire alarm system components were properly tested. All smoke detectors and all heat detectors were not being routinely tested. The findings were:<br><br>1. Review of the fire alarm system testing records showed 54 heat detectors were tested during 1/18/2009 inspection, but 57 detectors were tested during the 1/29/2010 inspection. Further review showed 117 smoke detectors were tested during the 2009 inspection and only 108 were tested during the 2010 inspection. On 12/15/10 at 3:10 PM The maintenance director reported he was unaware the contractor had tested different number of devices. He could not explain why the numbers had changed. | | | |
| K 062 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 062 | | |

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| K 062 | Continued From page 4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure sprinkler heads had the required minimum clearance between the sprinkler and the ceiling in 2 of 7 smoke compartments. The findings were:<br><br>Observation of the sprinkler system on 12/15/10 between 10:30 AM and 1:30 PM showed a sprinkler head in resident room #103 and one of ten in the kitchen had less than the required 1 inch gap between the deflector and the ceiling. At 10:44 AM the maintenance director reported the sprinklers were inspected quarterly by an outside contractor. The last inspection on 12/06/10 did not document the aforementioned lack of spacing. | K 062 | The facility will ensure automatic sprinkler systems are continuously maintained and in reliable operating condition and are inspected and tested periodically.<br><br>A) The sprinkler head in resident room 103 was adjusted to have the required 1" gap between the deflector and ceiling on 1/14/11. & IN THE KITCHEN.<br><br>B) The maintenance director will observe sprinkler heads quarterly to ensure correct spacing. If spacing is not appropriate it will be repaired immediately.<br><br>C) The maintenance director will audit sprinkler heads for spacing and report his findings at the monthly Performance Improvement meeting. This will occur for 3 months or until ongoing compliance. | 1/14/11 |
| K 069<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to ensure 1 of 1 deep fat fryer had adequate separation from open flames and failed to test the hood suppression system on a semi-annual basis. The findings were:<br><br>1. Observation on 12/15/10 at 1:15 PM of the deep fat fryer located in the kitchen showed the fryer was located 7 inches from the open flame range top. At the time of observation the maintenance director reported he was not aware an 8 inch tall steel baffle was required between | K 069 | The facility will ensure cooking facilities are protected in accordance with 9.2.3.<br><br>A) An 8" tall baffle was placed between the fryer and the range top on 1/6/11. The fire suppression system for the kitchen hood was tested on 1/4/11. | 1/6/11 |

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| K 069 | Continued From page 5<br>the two appliances when located less than 16 inches apart.<br><br>2. Review the the kitchen hood fire suppression testing records showed the last semi-annual test was performed more than six months prior to the survey. The last test was performed on 4/26/10. On 12/15/10 at 3:10 PM the maintenance director confirmed the suppression system had not been tested within the past six months. He stated he did not know why the contractor had not conducted the required test. | K 069 | B) The maintenance director will observe the deep fat fryer to ensure the placement of the steel baffle. The maintenance director will add the kitchen hood fire suppression system testing to his preventative maintenance log to ensure testing occurs timely.<br><br>C) The maintenance director will audit the steel baffle between the deep fat fryer and the range top open flame and report his findings to the monthly Performance Improvement meeting. This will occur for a period of 3 months or until ongoing compliance. The maintenance director will check his preventative maintenance log monthly to ensure the kitchen hood for fire suppression system is tested timely. This log will be reviewed monthly at the Performance Improvement meeting. | |
| K 074<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.<br><br>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13<br><br>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the | K 074 | | |

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| K 074 | Continued From page 6<br>facility failed to ensure all window curtains were flame retardant in 1 of 7 smoke compartments. The findings were:<br><br>Observation of window curtains on 12/15/10 between 10 AM and 1:30 PM showed the curtains in the Minimum Data Set (MDS) office and Bistro dining room did not have flame retardant documentation attached to them. At 10:27 AM the maintenance director reported he was not aware of the above mentioned requirement, he also confirmed the facility did not have flame retardant documentation for the noted curtains. | K 074 | The facility will ensure draperies, curtains, including cubicle curtains and other loosely hanging fabrics and films serving as furnishings or decorations of health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, standards for the installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.<br><br>A) The curtains in the MDS office and the bistro dining room will be sprayed with a flame retardant on or before 1/19/11.<br><br>B) The maintenance director will observe draperies in the facility to ensure they are fire retardant. If new draperies are found with no flame-retardant documentation they will be sprayed immediately with a flame retardant.<br><br>C) The maintenance director will educate the staff on the requirement of flame retardant draperies at the January all staff in service.<br><br>D) A quality-monitoring tool will be implemented to ensure draperies are fire retardant. This monitor will be completed monthly and reported quarterly at the Performance Improvement meeting for a period of 3 months or until ongoing compliance. | 1/19/11 |
| K 147 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure temporary wiring did not replace permanent fixed wiring and failed to ensure damaged electrical equipment was repaired in 2 of 7 smoke compartments. The findings were:<br><br>1. Observation of the electrical system on 12/15/10 at 10:03 AM showed the television set in resident room #215 was plugged into an extension cord. At the time of observation the maintenance director reported he was aware extension cords were prohibited. Furthermore, he reported the electrical system was inspected on a quarterly basis.<br><br>2. Observation of the electrical system 12/15/10 at 11:49 AM showed the electrical outlet in | K 147 | | |

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| K 147 | Continued From page 7<br>resident room #113 near bed A had a ground blade broke off inside the outlet. At the time of the observation the maintenance director confirmed damage. | K 147 | The facility will ensure electrical wiring and equipment is in accordance with NFPA 70.<br><br>A) The extension cord in room 215 was removed during survey. The ground blade broke off inside the outlet in room 113, was removed during survey.<br><br>B) The maintenance director will observe wiring and equipment to ensure accordance with NFPA 70. If issues are observed repairs or removal will occur immediately.<br><br>C) The maintenance director will educate the staff on the non-use of extension cords and the importance of notifying him of wiring issues at the January all staff in service.<br><br>D) The maintenance director will audit for the use of extension cords and the safety of outlets monthly and report his findings to the monthly Performance Improvement meeting. This will occur for a period of 3 months or until ongoing compliance. | 1/15/11 |