Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0013	A. BUILDING: _____ B. WING _____	04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET 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) COMPLETE DATE
S 000	General Comments A Life Safety Code survey was conducted at your facility on April 05, 2016 by the office of Healthcare Licensing and Surveys. (HLS) The facility was a fully sprinklered, 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 an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 107 residents.	S 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 solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the state operations manual.	
S7036	IPC Life Safety - Int'l Plumbing Code This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the existing plumbing systems in a manner that is in accordance with the WDH Chapter 3 Construction Rules and Regulations for Healthcare Facilities, in accordance with the original design, and in a safe and sanitary condition. The findings were: Observation of the emergency eyewash stations located in the laundry, clean utility in unit #1, and the clean utility in unit #2 on 04/05/16 from 10:00 AM to 11:00 AM revealed that tepid water was not provided to the eyewash via an ASSE 1071 - Performance Requirements for Temperature Actuated Mixing Valves for Plumbed Emergency Equipment - mixing valve in compliance with ANSI Z358.1 - Standard for Emergency Eye Wash and Shower Equipment. An interview with the Facility Maintenance Manager at the time of the observations confirmed that the eyewash was not provided with a tempering valve in	S7036	S7036 A. The mixing valves for eye wash stations on the nursing stations and in the laundry room in kitchen were ordered on 4/27/16. B. A 100% audit of all eye wash stations was completed with the survey team on 4/5/16. C. Eye wash stations will be inspected and temperatures taken on a monthly basis for the following three months. D. The maintenance director or designee will summarize and	5/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 4/27/16

STATE FORM 6899 5T1R11 If continuation sheet 1 of 2

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WY Dept of Health
APR 28 2016
Healthcare Licensing and Surveys

POC Accepted via Phone Call with Administrator Mathew Guerttman on 5/11/16 @ 10:23AM 34354

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S7036	Continued From page 1 compliance with the requirements of ANSI Z358.1. Ref: 2006 IPC, Sections 411, 608.6, and 608.13	S7036	report his findings to the P.I committee monthly. The P. I. committee is the quality assurance group within the facility that is composed of the Executive Director, Director of Nursing, Medical Director and other department managers. The group meets monthly to review clinical audits, customer service issues and other regulatory compliance issues. If a problematic trend(s) is identified the committee develops, or causes the development, of an action plan designed to mitigate the chance of recurrence. The results of the action plan are reviewed in subsequent months for effectiveness and modified as necessary.	