PRINTED: 02/18/2005
FORM APPROVED
OMB NO. 0938-0391

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

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 B. WING	02/10/2005

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

4/1/05

RECEIVED
MAR 18 2005
WYOMING DEPT OF HEALTH
HEALTH FACILITIES

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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 V (111) with a complete wet and dry sprinkler system. K6: Date of Plan Approval 1992 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=120;SNF/NF=120 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	K000 This Plan of Correction is submitted as required under Federal and State regulations and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, or that the scope or severity of deficiencies cited is correctly applied.	
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 sold-bonded core wood, 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 19.3.6.3.3 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities as of March 13, 2006.	K 018	The facility will ensure that smoke barriers are in accordance with regulations to ensure that all doors are fire resistant. 3/21/05	

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

Pat Miller - Revisions Revised per request Jason Jensen - 3/14/05

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.

Acceptance of this PC w/ Pat Miller, NHA on 4/1/05 @ 12 PM via telephone — JJ Jason Jensen

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 2/10/05 between 8 AM and 10 AM, the facility failed to protect 3 of 63 resident room corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Resident room #113, #111, and #121 had a gap between the top edge of the corridor door and the door frame that was greater than the aloud 1/8th of an inch. Maintenance staff verified the door was not smoke resistant.	K 018	Resident rooms #111, #113, #121 have been repaired by maintenance to ensure the doors are smoke resistant. Maintenance staff will monitor on preventative maintenance rounds and will repair as identified. Trends will be reviewed by QA and Safety Committees. 3/21/05	
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 and staff interview on 2/10/05 between 10 AM and 10:30 AM, the facility failed to protect 1 of 6 smoke barriers in accordance with NFPA 101 Section 19.3.7.3 and 4.6.12.2. The findings were: 1. The double doors for the smoke barrier	K 027	The facility will ensure that all self closing or automatic door openings are sealed to meet the fire safety codes. 1) The latch on double door outside of room #205 was repaired on 2/24/05. Maintenance will monitor door closures on rounds. Trends will be reviewed by QA and Safety Committees. 3/21/05	

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K 027	Continued From page 2 near resident room #205 were equipped with latching devices that did not fully latch the doors into the door frames. Maintenance staff verified the double doors did not fully latch in the door frame.	K 027		
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 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 on 2/10/05 between 9:30 AM and 10 AM, the facility failed to provide 2 of 9 hazardous areas with proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. The corridor door for the clean utility room by nurses station #2 was impeded from closing by a utility cart placed in the path of the door. Maintenance staff verified the corridor door was impeded from closing.	K 029	The facility will ensure that hazardous areas have proper separation in accordance with NPPA 101. 3/21/05 Cart was moved 2/10/05. Staff was inserviced on the importance and purpose of not impeding the door from closing. Maintenance to monitor on rounds. Trends will be reviewed by QA and Safety Committees. Inservice or disciplinary acts will be implemented. 3/21/05	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single	K 045		

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K 045	Continued From page 3 lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview on 2/10/05 between 10:30 AM and 11 AM, the facility failed to provide exit discharge lighting fixtures that prevent the loss of illumination if a single bulb failed for 1 of 9 exits in accordance with NFPA 101 Section 19.2.8. The findings were: 1. The exit near resident room #216 was only equipped with one exit discharge light that housed one light bulb. Maintenance staff verified the exit only had one light (bulb).	K 045	Bids have been obtained to install another light in the exit area outside of room #216. A letter requesting approval for installation will be submitted to the Department of Health and Human Services. Prior to installation, maintenance will monitor all exits on rounds to ensure that all exits are properly lit. Trends will be reviewed by Safety and QA Committees. 3/21/05	
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 record review and staff interview on 2/9/05 between 3 PM and 3:30 PM, the facility failed to conduct quarterly fire drills on each shift	K 050		

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K 050	Continued From page 4 In accordance with NFPA 101 Section 19.7.1.2. The findings were: 1. Review of the fire drill records revealed the third shift had not conducted a fire drill during the fourth quarter of 2004. Maintenance staff verified the third shift had not conducted a fire drill during the fourth quarter of 2004.	K 050	New Maintenance Supervisor has been inserviced on the importance of fire drills. Fire drills will be conducted quarterly on each shift. Maintenance will monitor. The QA Committee will review trends. ED and Supervisor to monitor. 3/21/05	3/28/05
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. Except for self-testing systems, fire alarm systems are manually tested monthly. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained periodically and records of maintenance 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 and staff interview on	K 051	The facility will ensure that fire alarms system is maintained and tested in accordance with Fire Safety Code NFPA 72. 3/21/05	

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K 051	Continued From page 6 2/9/05 between 3 PM and 4 PM, the facility failed to maintain, test, and document the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The findings were: 1. Review of the maintenance records revealed the biannual smoke detector sensitivity test was last conducted on 10/22/02, more than the allowed two years. 2. Review of the maintenance records revealed the Waterflow alarm device, Supervisory signal devices, and the Main drain had not been tested for the third or fourth quarters of 2004 as required by the Code. 3. Maintenance staff verified the smoke detector sensitivity test had not been conducted in the past two years and the Waterflow, Supervisory Signal, and Main Drain tests had not been conducted during the third and fourth quarter of 2004.	K 051	The smoke detector sensitivity test was completed on 2/12/05. Water flow and main drain tests were conducted on 2/25/05 and 3/1/05. Maintenance will review Preventative Maintenance Book to ensure test are done timely. ED and Maintenance Supervisor to monitor. Trends will be reviewed by QA and Safety Committees. Inserviceor corrections will be made as needed. 3/21/05	3/21/05
K 064 SS=E	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, 9.7.4.1, NFPA 10 This STANDARD is not met as evidenced by: Based on observations and staff interview on 2/9/05 between 2:30 PM and 4 PM, the facility failed to maintain and test 3 of 15 portable fire extinguisher in accordance with NFPA 10 Section 4-4.1 and 4-4.3 respectively. The findings were. 1. The portable fire extinguisher in the electrical room had the last yearly inspection performed in January 2004 more than one year	K 064		

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K 064	Continued From page 6 ago. 2. The portable fire extinguisher near resident room 119 had the last yearly inspection performed in October 2003 more than one year ago. 3. The portable fire extinguisher in the electrical room was manufactured in 1998. The extinguisher was more than 6 years old and had not received the required 6 year maintenance. 4. Maintenance staff verified the two extinguisher had not been serviced in the past year and the 6 year maintenance had not been performed.	K 064	Fire extinguishers were checked by the contractor and updated as needed on 2/11/05. Maintenance will monitor fire extinguishers on monthly basis to ensure they are updated.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview on 2/10/05 between 8 AM and 11 AM, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8 and NFPA 99 Section 3-5.2.2.3. The findings were: 1. The beauty shop, resident rooms #119, #205, and #218 all had power strip bars attached to the wall used as permanent wiring. 2. The special care unit medication refrigerator was not supplied with emergency power as required by the Code. 3. Maintenance staff verified the power strip bars were attached to walls for permanent wiringand the medication refrigerator was not on emergency power.	K 130	The facility will ensure that all electrical systems meet the intent of Life Safety Code NFPA 70 & 99. 3/21/05 Although the refrigerator was plugged into the emergency outlet, the outlet was not marked as an emergency outlet. Maintenance has appropriately marked the outlet and will monitor on rounds. 3/21/05	