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 _____	07/17/2008

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

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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 Health Care, of the National Fire Protection Association. The facility was a single story building of Type V(111) construction built in 1992. The building was equipped with a supervised automatic wet sprinkler system and addressable fire alarm system.	K 000		
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, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure one smoke partition was maintained as required in 1 of 6 smoke compartments. The findings were: Observation on 7/15/08 at 10:48 AM revealed a 6" by 10" hole cut into the dry wall at floor level. Water pipes from a water heater passed through the hole. The facility manager stated at the time of the observation that the drywall had been cut to allow a plumbing repair to the water pipes, and the drywall had not yet been repaired.	K 012	K012 The facility will ensure smoke partitions are maintained as required. This will be accomplished by: A) The 6" X 10" hole in the drywall was repaired. B) All smoke partitions will be maintained throughout the building. C) The maintenance director will monitor the building to ensure smoke partitions are maintained, especially after repairs performed internally or from an outside contractor. D) A quality monitoring tool will be developed to all ensure smoke partitions are maintained. The maintenance director will report quarterly to the facility's performance improvement committee.	8/22/08
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	K 018		

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

Lisa DeLafayle — Executive Director — 8/10/08

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.

AUG 12 2008

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K 018	Continued From page 1 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 and staff interview, the facility failed to ensure corridor doors resisted the passage of smoke in 2 of 6 smoke compartments. The findings were: Observation on 7/16/08 between 11:11 AM and 1:48 PM revealed doors did not close in their frames unless force in excess of 5 foot pounds of pressure was applied to following resident rooms: #105, #221, #228 and #229. Interview with the facility maintenance manager at that time confirmed the doors did not seat in their frames without the increased pressure.	K 018	K018 The facility will ensure that corridor doors do not resist closure. This will be accomplished by: A) Corridor doors #105, #221, #228, and #229 were adjusted to ensure closure in their frames would not require more than 5 foot pounds of pressure. B) All corridor doors will be checked and adjustments will be made to ensure there is no resistance greater than 5 pounds pressure to close doors in their frames. C) The maintenance director will monitor corridor door closures on a quarterly basis. D) A quality monitoring tool will be developed and maintained. Quarterly the results of the corridor door closure monitor will be reported at the facility's performance improvement committee by the maintenance director.	8/22/08
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	K 029		

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K 029	Continued From page 2 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 failed to ensure one hazardous area was separated from other spaces by smoke resistant assemblies. The findings were: Observation on 7/15/08 at 9:45 AM revealed the bathroom near the staff copy room was also used to store paper products. Several shelves in the bathroom contained reams of photocopy paper. The door to the bathroom did not have a self closure device attached. Interview with the facility administrator at that time confirmed the room was used for paper storage.	K 029	K029 The facility will ensure hazardous areas are separated from other spaces by smoke resistant partitions and doors. This will be accomplished by: A) A self-closure device was installed on the bathroom door near the staff copy room. B) Other doors in the facility will be evaluated to ensure hazardous areas are separated from other spaces by a smoke resistant partitions and doors. C & D) A quality monitoring tool will be developed and maintained. Semi-annual results will be reported at the facility's performance improvement committee by the maintenance director.	8/22/08
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 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, the	K 045		

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K 045	Continued From page 3 facility failed to ensure a fully lit corridor exit sign in 1 of 6 smoke compartments. The findings were: Observation on 7/15/08 at 5:15 PM revealed one of two light bulbs was burned out in one corridor exit sign in front of the staff mail boxes. Interview with the facility maintenance manager at that time confirmed the bulb was burned out.	K 045	K045 The facility will ensure egress areas including exits are illuminated at all times. This will be accomplished by: A) The burnt out light bulb in the corridor exit sign in front of the staff mailboxes was replaced. B) All exit lights will be checked to assure they are illuminated at all times. C&D) A quality monitoring tool will be developed and maintained. Quarterly results of the monitoring will be reported to the performance improvement committee by the maintenance director.	8/22/08
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance 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 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 2 of 9 fire alarm system components were tested. The findings were: Review of the fire alarm and sprinkler testing records revealed the following concerns: a. The semi annual voltage test for the batteries associated with the annunciator panel was last performed 5/05/06, a time period greater than 6 months. b. The second quarter 2008 sprinkler system test was not conducted. The most recent test was	K 052		

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K 052	Continued From page 4 conducted on 3/25/08. The facility maintenance manager confirmed there were no other records to review.	K 052	K052 The facility will ensure fire alarm system components are tested according to NFPA 70 and 72. This will be accomplished by: A) A new enunciator panel was installed with new batteries on 7/27/08. Western Fire Protection Company performed the 3rd Qt. sprinkler system test on 8/4/08 B) All fire alarm system components testing applicable to requirements of NFPA 70 and 72 will be reviewed and the proper testing will be performed. C & D) A monitoring tool will be developed and maintained for testing of the fire alarm system components. The maintenance director will report quarterly on the testing to the facility's performance improvement committee.	8/22/08
K 062 SS=E	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 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire suppression (sprinkler) system was properly maintained. The findings were: Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed a gap between the sprinkler head escutcheon and the ceiling in the kitchen. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed two of four sprinkler heads in the ceiling of the special care unit dining room had cellophane tape and residual crepe paper streamers still attached to the sprinkler heads. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed one sprinkler head was coated with dirt and grease in the walk-in refrigerator. One sprinkler head in the facility walk-in freezer and one sprinkler head in resident room #108 were similarly soiled. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed the sprinkler head at the following locations were mounted into the ceiling	K 062		

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K 052	Continued From page 4 conducted on 3/25/08. The facility maintenance manager confirmed there were no other records to review.	K 052		
K 062 SS=E	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 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire suppression (sprinkler) system was properly maintained. The findings were: Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed a gap between the sprinkler head escutcheon and the ceiling in the kitchen. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed two of four sprinkler heads in the ceiling of the special care unit dining room had cellophane tape and residual crepe paper streamers still attached to the sprinkler heads. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed one sprinkler head was coated with dirt and grease in the walk-in refrigerator. One sprinkler head in the facility walk-in freezer and one sprinkler head in resident room #108 were similarly soiled. Observation on 7/16/08 at between 1:11 PM and 3:22 PM revealed the sprinkler head at the following locations were mounted into the ceiling	K 062	K062 The facility will ensure the automatic sprinkler system is continuously maintained in a reliable operating condition, inspected and tested periodically. This will be accomplished by: A) The sprinkler head escutcheon in the kitchen was adjusted to relieve the gap between the sprinkler head and the ceiling. The cellophane tape and residual crepe paper streamers were removed from the two sprinkler heads in the ceiling in the Special Care Unit. The sprinkler head(s) in the walk-in refrigerator and walk in freezer was cleaned so the dirt and grease were removed. The sprinkler head in resident room #108 was cleaned. The sprinkler heads in the following areas were adjusted down to adequately project from the ceiling surface - Sprinkler head over Unit 2 nurses stations, two sprinkler heads in the hallway near the	8/22/08

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K 062	Continued From page 5 in such a way that the heads did not adequately project from the ceiling surface. a. One over the unit #2 nursing station. b. Two in the hallway near the entrance into the rehabilitation gym. c. Two in the hallway in front of the residents' lounge. d. One near the facility exit door in the vicinity of the unit #2 nurses' station. Interview with the maintenance manager at this time confirmed a gap existed between the escutcheons and the ceiling in the kitchen, the obstructions by grease and tape and the insufficient projection of the sprinkler heads as previously noted.	K 062	entrance into the rehabilitation gym, two sprinkler heads in the hallway in front of the resident's lounge and one sprinkler head near the facility exit door in the vicinity of the unit #3 nurses stations. B) Components of the sprinkler system will be monitored to ensure cleanliness, no gap between the sprinkler head escutcheon and the ceiling, and sufficient projection of the sprinkler heads. C &D) A monitoring tool will be developed and maintained for reliable operation of the sprinkler system. The maintenance director will report the findings of the monitoring quarterly to the facility's performance improvement committee.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the medication refrigerator at one of two nurses' stations was plugged into an emergency outlet and that alcohol based hand rub (ABHR) dispensers were not installed over ignition sources in 3 of 6 smoke compartments. The findings were: Observation on 7/16/08 at 3:48 PM revealed the medication refrigerator in the medication storage room of the special care unit (SCU) was plugged into a white electrical outlet. Also observed were several red covered outlets over the counter in the SCU. Interview with the maintenance manager at that time confirmed the refrigerator	~~K 130~~		

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K 130	Continued From page 6 was plugged into a white outlet, and the red outlets were emergency outlets. ABHR concerns were as follows: a. The day room (also called the resident lounge) had an ABHR dispenser attached to the wall directly over and approximately 12 inches above a light switch. b. The assistive dining room had an ABHR dispenser attached to the wall directly over and approximately 24 inches above a light switch. c. The dirty linen room by the Unit 2 nurses' station had an ABHR dispenser attached to the wall directly over and approximately 24 inches above a light switch. d. The day room in the SCU had an ABHR dispenser attached to the wall directly over and approximately 12 inches above a fire alarm pull station.	K 130	K130 The facility will ensure that all medication refrigerators will be plugged into emergency outlets and that alcohol based hand rub dispensers are not installed over ignition sources. This will be accomplished by: A) The electrical outlet in the medication storage room in the special care unit was tested and is on the emergency power system. The white outlet cover was changed to an orange outlet cover. The ABHR dispensers located in the day room, assistive dining room, dirty linen room on Unit 2 nurses station and the SCU day room were all removed and relocated to other positions in the rooms away from an ignition source. B) All emergency electrical outlets will be identified by the orange outlet cover. ABHR dispensers will be installed away from ignition sources throughout the building. C & D) A monitoring tool will be developed and maintained to assure that all emergency	8/22/08
K 147 SS=E	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 and staff interview, the facility failed to maintain the required work space in front of electrical equipment in 2 of 6 smoke compartments. The findings were: Observation on 7/16/08 at 1:23 PM revealed a wall mounted circuit panel (Dukane Communications Panel) in the "blood spill" (AKA clean utilities room or emergency eye wash room). In front of the panel within 36 inches was a med cart.	K 147		

K130

electrical outlet covers are orange and that all ABHR dispensers are installed away from an ignition source. The maintenance director will report the findings of the monitor semiannually to the facility's performance improvement committee.

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K 147	Continued From page 7 Observation on 7/16/08 at 2:22 PM revealed two wall mounted electrical panels (KA & EK) in the kitchen. In front of the KA panel within 36 inches was a dirty linen bucket. In front of the EK panel within 36 inches was a food tray cart. Observation on 7/16/08 at 2:48 PM revealed the wall thermostat in the residents bathing room in the special care unit was missing a cover plate exposing electrical contacts and wires. Interview with the facility manager at the above times confirmed the panels did not have the required 36 inch space in front of them and the missing thermostat cover plate.	K 147	K147 The facility will ensure that the required work space will be maintained in front of electrical equipment. This will be accomplished by: A) The med cart was removed from in front of the circuit panel (Dukane Communications Panel) in the clean utility room. The dirty linen bucket was removed from in front of the KA bucket and the food tray cart was removed from in front of the EK panel in the kitchen. The cover plate was replaced on the thermostat in the residents bathing room on SCU. B) All electrical circuit panels will be given a clearance of obstruction up to 36" in front of the panel. All thermostats and other electrical receptacles will have the required covers on them at all time. C&D) A monitoring tool will be developed and maintained to ensure that all electrical circuit panels are given a	8/22/08

K 147

clearance of 36" in front of the panel at all times and that all electrical receptacles have the appropriate covers. The maintenance director will report the findings of the monitor semiannually to the facility's performance improvement committee.