STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 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). The facility was a fully sprinkled single story building of Type V (111) construction built in 1987. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and a zoned fire alarm system. The facility has a capacity of 160 certified Medicare and Medicaid beds.	K 000	This plan of correction constitutes Life Care Center of Cheyenne's credible allegation of compliance with the Life Safety Code Standard effective 11/16/09. POC ACCEPTED W/ BRIAN MERLI, ASST. ADMINISTRATOR DWJ/11/19/09.	
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 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 hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were: Observation on 10/27/09 at 11:35 AM showed the	K 029	K029 The facility will maintain doors that are smoke resistant. 1. The middle laundry room corridor door was replaced on 11/17/09 with a new smoke resistant door. 2. Maintenance will randomly audit smoke resistant doors quarterly to ensure smoke resistance. Any doors found to not be smoke resistant will be immediately repaired or replaced. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	11/17/09

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

Executive Director 11/17/09

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

11/19/09

(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 029	Continued From page 1 middle laundry room corridor door was not smoke resistant. The door was cracked along the top hinge and sagged when open so that it would bind with the door frame. At the time of observation the maintenance director reported he was aware the door was damaged. He further reported that the door had been repaired several times.	K 029		
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 escutcheon rings were smoke resistant in 2 of 6 smoke compartments. The findings were: Observation on 10/27/09 between 11 AM and 1 PM showed the escutcheon rings in the clean linen room near resident room #411, the men's restroom near the dining room, and the service corridor above the electrical room door were not smoke resistant. A gap of at least 1/2 inch was noted between the rings and the ceiling tile at each location. At the time of observation the maintenance director reported the rings were inspected quarterly to ensure they were smoke resistant.	K 062	K062 The facility will ensure that automatic sprinkler systems are continuously maintained in reliable operating condition. 1. The escutcheon rings and ceiling tiles in the clean linen room near resident room #411, the men's restroom near the dining room, and the service corridor above the electrical room door were replaced on 11/7/09 providing a smoke resistant barrier. 2. Maintenance will randomly audit the escutcheon rings quarterly to ensure that automatic sprinkler systems are continuously maintained in reliable operating condition. . 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	11/17/09