STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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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 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 (000) construction with plan approval in 1961. The building was equipped with a supervised automatic wet sprinkler system with four anti-freeze branches and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 91 residents.	K 000	**K –18** **Corrective Action**: Replaced latch in room #136 on 1/23/2012, and repaired latch in room #104 on 1/23/2012. **Id of Others:** An audit of all corridor openings and no other issues identified. **System Measures**: All corridor doors will be checked weekly x 4 weeks than quarterly, will be reported on TELS and brought to safety meeting. All necessary repairs will be made at the time of discovery. Maintenance Director/designee will keep in stock 2 extra latching mechanisms. **Monitoring:** Maintenance Director/designee will bring TELS reporting to QA & A and the QA &A committee will track and trend for 3 months. **Date of Compliance** : 2/28/2012	
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 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.	K 018	**K-29** **Corrective Action**: North Hall Nurses supply closet repaired on 1/24/2012. Adjustments made to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume — TITLE: NHA — (X6) DATE: 2/13/2012

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.

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healthcare Licensing and Surveys

POC ACCEPTED W/ MODIFICATION ON 2/23/12
WITH ENDORSEMENT REMOVED, NHA

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 2 of 6 smoke compartments. The findings were: 1. Observation of resident room #136 on 1/19/12 at 10:34 AM showed the latch bolt required excessive force to retract from the strike plate. Further operation of the latch showed it would not retract at all from either side of the door. In this condition, there was a likelihood that the two residents would not have been able to reopen the closed door. The environmental service manager had the latch removed at the time of the observation, but a replacement latch was not available. The missing latching mechanism left a 2 inch circular hole in the corridor door. 2. Observation of resident room #104 on 1/19/12 at 11:48 AM showed the corridor door latching mechanism would not insert the latch bolt into the strike plate. At the time of the observation the environmental service manager could not explain why the latch had not been noticed and repaired during the quarterly inspections.	K 018	latch mechanism on the North Hall Housekeeping closet on 1/24/2012. **ID of Others**: Audit of all hazardous areas and no other issues were found. **System Measures**: Maintenance Director/designee will conduct checks on all hazardous areas x4 weeks than quarterly. All repairs will be done and report on TELS and brought to safety meeting. **Monitoring :** Maintenance Director/designee will will track and trend thru audits and will bring results to QA &A committee for 3 months. Date of Compliance: 2/28/2012 **K-46** **Corrective Action**: A 90-minute testing of the emergency lighting was tested on 2/9/2012. **ID of Others**: An audit was done on 2/9/2012 of all emergency lighting and the emergency light for the generator was identified. Battery replaced on 2/9/2012.	
K 029 SS=E	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	K 029		

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K 029	Continued From page 2 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: 1. Observation of the north hall nurses supply closet on 1/19/12 at 10:19 AM showed the corridor door had a 1/2 inch by 1 1/2 inch piece of the door missing on the latch side of the door where carts had rubbed the wood away. Further observation showed the self-closing device attached to the door was not able to fully latch the door into the door frame, with three attempts. At the time of the observation the environmental service manager could not explain why the hole and latching capability of the aforementioned door had not been noticed and repaired during the quarterly inspections. 2. Observation of the north hall housekeeping closet on 1/19/12 at 10:22 AM showed the self-closing device attached to the corridor door was not able to fully latch the door into the door frame, with three attempts.	K 029	**System Measures** : Maintenance Director /designee will conduct emergency lighting annually and report on TELS. NHA to do random checks of TELS report. **Monitoring:** Maintenance Director /designee will bring TELS reporting to QA&A and the QA&A committee will track and trend for 3 months. Date of Compliance: 2/28/2012 **K-50** Fire Drills **Corrective Action:** Education to Maintenance Director by Divisional Plant Operations was conducted on 2/8/2012. **Id of Others:** An audit for 2012 fire drills was conducted and no issues found. **Systems Measures**: We will conduct a fire drill on each shift monthly at varied times and record. Record will be brought to safety meeting. NHA will conduct random checks of Fire drill log.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

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K 046	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 2 emergency battery light tests were performed. The findings were: Review of the emergency battery light testing records showed the facility could not verify the last time the annual 90 minute test was performed. On 1/19/12 at 2:30 PM the environmental service manager was not aware of the last time the test was performed. Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046	**Monitoring:** Maintenance Director/designee will track and trend thru audits and will bring results to QA&A and the QA&A committee will track and trend for 3 months. Date of Compliance: 2/28/2012 **K- 52** **Correction Action**: Education to Maintenance Director/designee to activate fire panel each month. Vendor has been called to program the fire panal so that all trouble signals will be reported to central monitoring station on or before 2/28/2012. **ID of Others**: No other fire panels exists.	
K 050 SS=E	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	K 050	**System Measures**: Maintenance Director /designee will request weekly activation logs for 4 weeks than monthly and brought to safety meeting. **Monitoring:** Maintenance Director/designee will track and trend thru audits and will bring results to QA&A committee for 3 months.	

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K 050	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were conducted on each shift for each quarter during 3 of the past 4 quarters. The findings were: Review of the fire drill records showed the shifts occurred between 6 AM to 2 PM, 2 PM to 10 PM and 10 PM to 6 AM. Further review showed a drill had not been conducted on the third shift during the first and second quarters of 2011. A drill was not conducted on the first shift during the fourth quarter of 2011. On 1/19/12 at 2:30 PM the environmental service manager could not explain why the fire drills had not been conducted.	K 050	. Date of Compliance: 2/28/2012 SEE MODIFIED PoC FOR K-056 ON PAGE 7A. **K-56** **Corrective Action:** Vendor has been contacted for replacement of sprinkler head. **ID of Others**: All other rooms were check and no other issues were found. **System Measures**: Maintenance Director/designee will supervise that the sprinkler system is properly maintained. Documentation of maintenance will be reported in TELS and brought to safety meeting. **Monitoring:** Maintenance Director/designee will bring TELS report to QA&A and the QA&A committee will track and trend for 3 months. Date of Compliance: 2/28/2012	
K 052 SS=F	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 the fire alarm receiver was	K 052	**K-74** **Corrective Action**: Drapes in employee lounge was removed on 2/1/2012.	

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K 052	Continued From page 5 tested during 3 of the past 12 months and failed to ensure trouble signals reported to the central monitoring company. The findings were: 1. Review of the fire alarm system testing records showed the receiver was not tested with the activation of the fire alarm during March, June, and September of 2011. On 1/19/12 at 2:30 PM the environmental service manager reported he was unaware the receiver device was required to be tested on a monthly basis. 2. Review of the sprinkler system testing records showed the supervisory signal device activated the fire alarm panel trouble signal, but the trouble signal did not report to the central monitoring company. Review of the past four quarterly sprinkler inspection reports showed the same comment was made on each report. On 1/19/12 at 2:30 PM the environmental service manager reported he was unaware all indicators in the fire alarm panel are required to be transmitted to the central monitoring company. He also reported that the sprinkler contractor told him this configuration was acceptable and that is why he did make changes to the panel. Reference, NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 3-8.4.4.2.2 Means provided to transmit trouble signals to supervising stations shall be arranged so as to transmit a trouble signal to the supervising station for any trouble condition received at the protected premises control unit, including loss of primary or secondary power. Table 7-3.2 Testing Frequencies. 23. Receivers,.....monthly	K 052	**ID of Others:** An audit conducted and 3 activity boards were identified. Material was treated and logged. **System changes** :Maintenance Director/designee educated on the importance of keeping a flame retardant documentation by the Divisional Plant operation director on 2/8/2012. Maintenance Director/designee will check daily for materials that need to be treated and will bring the flame retardant documentation to morning meeting daily times 4 weeks than as needed. NHA/designee to do random checks for materials that have not been treated. **Monitoring:** Maintenance Director/designee to track and trend thru audits and will bring results to QA& A committee. QA&A committee will monitor for effectiveness for 3 months. Date of Compliance: 2/28/2012	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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

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K 056 SS=D	Continued From page 6 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure complete sprinkler coverage in 1 of 6 smoke compartments. The findings were: Observation of resident room #147 on 1/19/12 at 10:53 AM showed the single sprinkler head in the bedroom was located 11 feet from the far wall. Further observation showed an abandoned hole were an existing head had been previously located, and the hole was filled in with join compound. The abandoned hole was located 5 feet from the aforementioned far wall. Review of the sprinkler records on 1/19/12 at 1:07 PM showed the sprinkler line above this room froze and broke in January 2011. At the time of the record review the environmental service manager could not explain why the head was not replaced after the sprinkler pipe was replaced.	K 056	**K-56** **Corrective Action:** Vendor has been contacted for replacement of sprinkler head. **ID of Others:** All other rooms were check and no other issues were found. **System Measures:** Maintenance Director/designee will supervise that the sprinkler system is properly maintained. Documentation of maintenance will be reported in TELS and brought to safety meeting. **Monitoring:** Maintenance Director/designee will bring TELS report to QA&A and the QA&A committee will track and trend for 3 months **Because of our DPNA compliance date we are requesting a time limited waiver. This is requested because of contractor timeliness.** Date of Compliance: ~~3/20/2012~~ PROJECT COMPLETED 3/20/12	2/22/12

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K 056 SS=D	Continued From page 6 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure complete sprinkler coverage in 1 of 6 smoke compartments. The findings were: Observation of resident room #147 on 1/19/12 at 10:53 AM showed the single sprinkler head in the bedroom was located 11 feet from the far wall. Further observation showed an abandoned hole were an existing head had been previously located, and the hole was filled in with join compound. The abandoned hole was located 5 feet from the aforementioned far wall. Review of the sprinkler records on 1/19/12 at 1:07 PM showed the sprinkler line above this room froze and broke in January 2011. At the time of the record review the environmental service manager could not explain why the head was not replaced after the sprinkler pipe was replaced.	K 056	**K- 141** **Corrective Action:** All no smoking signs were replaced on rooms #101,#103,#104. All other corridor doors was posted with no Smoking signs on 1/18/2012. **ID of Others**: Whole house audit done and no other issues identified. System Measures. Maintenance Director/designee to do daily audits for posting of No Smoking signs where oxygen is in use for 4 weeks and than random audits. **Monitoring:** Maintenance Director/designee will bring results to QA&A committee and will be track and trend results for effectiveness and determine if further review and recommendations is necessary for compliance. Date of Compliance : 2/28/2012 **K-147**	

B

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K 056	Continued From page 7 Reference, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-5.3.2 Maximum Distance From Walls. The distance from sprinklers to walls shall not exceed one-half of the allowable maximum distance between sprinklers. The distance from the wall to the sprinkler shall be measured perpendicular to the wall. Table 5-6.2.2 (b) Protection Areas and Maximum Spacing (Standard Spray Upright/Standard Spray Pendent) for Ordinary Hazard Construction Type ... ...All System Type ... ...All Protection Area ... ...130 ft2 Spacing ... ...15 ft	K 056	**Corrective Action**: Power strip was plugged into wall socket. Corrected at time of survey. **ID of Others** : Audit was conducted and no other issues were found. **System Measures**: Maintenance Director/designee will check all rooms and offices for extensive cords and miss use of power strips weekly for 4 weeks and then random audits. NHA/designee will randomly check for extension cords and improper use of power strips. **Monitoring:**Maintenance Director/designee will bring results to QA&A committee and will be track and trend results for effectiveness and determine if further review and recommendations is necessary for compliance. Date of Compliance: 2/28/2012	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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. 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 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	K 074		

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K 074	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure loose hanging fabrics were flame retardant in 1 of 6 smoke compartments. The findings were: Observation of the staff lounge on 1/19/12 at 11:27 AM showed flame retardant documentation was not attached to the curtain. At the time of the observation the environmental service manager reported the facility did not have flame retardant documentation for that curtain. He also stated that he did not have a log showing curtains were protected with a flame retardant solution.	K 074		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, facility policy, and staff interview, the facility failed to ensure areas where oxygen was in use were posted with No Smoking signs in 1 of 6 smoke compartments. The findings were: Observation on 1/19/12 between 11:30 AM and 12 PM showed oxygen concentrators were in use in resident room #101, #103, and #104. Further observation showed the corridor doors were not posted with No Smoking signs. At the time of the observations the environmental service manager	K 141		

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K 141	Continued From page 9 reported the rooms are required to have signs because the facility has a interior smoking room. He could not explain why the rooms were not appropriately signed.	K 141		
K 147 SS=D	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 ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 6 smoke compartments. The findings were: Observation of the social service office on 1/19/12 at 10:12 AM showed the air conditioning unit was plugged into two surge protectors in-line. At the time of the observation the environmental service manager reported he was aware chaining of electrical adapters was prohibited. Furthermore, he could not explain why the two surge protectors had not been observed and modified during the quarterly inspections. Reference, NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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