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Healthcare Licensing and Surveys

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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
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/25/2012

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

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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, New and Existing Health Care, of the National Fire Protection Association. The facility was a single story building separated by five, 2-hour rated fire barrier walls of Type V (111) construction with plan approval in 1987 and 2008. 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 160 certified Medicare and Medicaid beds with a census of 133 residents.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, blue print review and staff interview, the facility failed to ensure 2 of 5 fire barrier double doors were maintained and smoke resistant. The findings were: 1. Observation of the dining hall cross corridor fire double doors on 10/24/12 at 10:50 AM showed	K 011	K011 The facility will ensure that fire barrier double doors were maintained and smoke resistant. This will be accomplished by: A) The corridor fire double doors near the dining hall will latch on or before 12/11/12. Adjustments were made to the latching mechanism on the corridor fire double doors near resident room #112 on 10/25/12. B) Maintenance staff will audit corridor fire double doors to ensure proper latching occurs. Any problems will be immediately repaired or replaced.	12/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/20/12

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.

POC ACCEPTED W/ BRIAN MERRELL, ED., DN 11/21/12

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K 011	Continued From page 1 one of the doors would not stay latched when pressure was applied to the handle. At the time of the observation the maintenance director could not explain why this was not noticed and repaired during the quarterly safety inspections. On 10/24/12 at 2:45 PM blue print review confirmed the doors were in a 2-hour fire rated wall. 2. Observation of the cross corridor fire double doors near resident room #112 on 10/24/12 at 2:34 PM showed one of the doors was equipped with a top and bottom latching system. Further observation showed the bottom latch bar was removed from the other door. At the time of the observation the maintenance director reported he was unaware the barrier hardware is required to be maintained to the level it was installed. On 10/24/12 at 2:45 PM blue print review confirmed the doors were in a 2-hour fire rated wall. Reference NFPA 101, 2000 Edition; 4.6.7* Modernization or Renovation. Any alteration or any installation of new equipment shall meet, as nearly as practicable, the requirements for new construction ... Existing life safety features that do not meet the requirements for new buildings, but that exceed the requirements for existing buildings, shall not be further diminished. In no case shall the resulting life safety features be less than those required for existing buildings. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door ...	K 011	C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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K 018 SS=D	Continued From page 2 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. 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 7 smoke compartments. The findings were: Observation on 10/24/12 between 11 AM and 2:30 PM showed the activities room and 200 hall pantry corridor doors were equipped with self-closing devices. Further observation showed neither of self-closing devices were able to fully latch the doors into the door frames. On 10/24/12 at 11:04 AM the maintenance director could not explain why the doors had not been noticed and	K 018	K018 The facility will ensure corridor doors have no impediment to the closing of the doors. This will be accomplished by: A) The doors and latches were adjusted during the survey to ensure that the 200 hall pantry and activity room securely closes. B) The maintenance staff will quarterly observe corridor room doors and if a door fails to securely close, maintenance will immediately adjust doors and latches to ensure the doors close securely. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	12/11/12

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K 018	Continued From page 3 repaired during the quarterly safety inspections.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 7 smoke barrier walls was smoke resistant. The findings were: Observation on 10/24/12 at 4:35 PM showed the attic smoke barrier wall near resident room # 401 had a 2 inch unsealed cable penetration. At the time of the observation the maintenance director could not explain why these holes had not been noticed and repaired during the quarterly safety inspections.	K 025	K025 The facility will ensure that smoke barrier walls are free from unsealed penetrations. This will be accomplished by: A) The smoke barrier wall penetration in the attic above room #401was sealed and filled with fire caulk on 10/25/12. B) The maintenance staff will inspect fire barrier walls in the attic and repair if necessary on a quarterly basis. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	12/11/12
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	K 062	K062 The facility will ensure sprinkler heads were not corroded or obstructed. This will be accomplished by:	12/11/12

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K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sprinkler heads were not corroded or obstructed in 2 of 7 smoke compartments. The findings were: 1. Observation of the laundry on 10/24/12 at 11:10 AM showed the sprinkler head above the back of the dries was corroded. At the time of the observation the maintenance director reported the sprinkler system was inspected annually by an outside contractor. The 9/17/12 sprinkler inspection report did indicate any heads were corroded. 2. Observation of resident room #118 on 10/24/12 at 3:31 PM showed the cap for the recessed sprinkler head had been caulked shut. The caulking would potentially prevent the sprinkler head from activating. At the time of the observation the maintenance director could not explain when or why the cap had been sealed shut. The 9/17/12 sprinkler inspection report did indicate any heads were damaged or obstructed. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1998 Edition; 2-2.1.1* Sprinklers shall be visually inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged or loaded, or in the improper orientation.	K 062	A) The sprinkler head above the back of the dryers in laundry was replaced with a steel pipe coming out of the attic on 11/12/12. The sprinkler head in resident room #118 was cleaned of caulking and reinstalled on 10/25/12. B) The maintenance staff will inspect sprinkler heads and repair if necessary on a quarterly basis to ensure they are not corroded or obstructed. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

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K 064 SS=D	Continued From page 5 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were tested on a monthly basis in 1 of 7 smoke compartments. The findings were: Observation of the kitchen "K" type portable fire extinguishers on 10/24/12 at 10:58 AM showed a monthly inspection had not occurred since the July 2012. At the time of the observation the maintenance supervisor could not explain why the extinguisher had not been inspected on a monthly basis. Reference NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition; 4-3 Inspection. 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals	K 064	K064 The facility will ensure portable fire extinguishers were tested on a monthly basis. This will be accomplished by: A) Fire extinguisher was tested on a monthly basis as required. Maintenance staff was re-educated regarding documentation in maintenance log and fire extinguisher tag. B) The maintenance staff will test fire extinguishers on a monthly basis to ensure they functioning appropriately. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	12/11/12
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.	K 074	K074 The facility will ensure that wall blankets were flame retardant. This will be accomplished by: A) The wall blanket in resident room #111 had fire retardant applied on 11/9/12. The fire retardant documentation is attached.	12/11/12

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K 074	Continued From page 6 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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure wall blankets were flame retardant in 1 of 7 smoke compartments. The findings were: Observation of resident room #111 on 10/24/12 at 2:12 PM showed the wall blanket did not have flame retardant documentation attached. At the time of the observation the maintenance director reported he was unaware the blanket was installed and he did not have documentation of a flame retardant solution applied to it.	K 074	B) B) The maintenance staff will audit resident rooms quarterly to ensure that wall blankets have flame retardant documentation attached. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;	K 143	K143 The facility will ensure liquid oxygen containers are stored inside the oxygen storeroom. This will be accomplished by: A) The liquid oxygen tank was picked up by vendor on 10/24/12.	12/11/12

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K 143	Continued From page 7 (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure liquid oxygen containers were stored inside the oxygen storeroom. The findings were: Observation on 10/24/12 at 11:19 AM showed a liquid oxygen tank was unattended in the service corridor near the staff lockers. At the time of the observation the maintenance director could not explain why the liquid oxygen tank was not put in the liquid oxygen storeroom.	K 143	B) The maintenance staff will visually audit the service corridor near the staff lockers daily for unattended liquid oxygen tanks. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
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 7	K 147	K147 The facility will ensure temporary electrical wiring does not replace permanent fixed wiring. This will be accomplished by: A) The 3-way adapter and one surge protector in resident room #205 was removed and a single surge protector was plugged into an outlet on 10/24/12.	12/11/12

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K 147	Continued From page 8 smoke compartments. The findings were: Observation of resident room #205 on 10/24/12 at 3:17 PM showed the telephone power cord was plugged into two surge protectors in-line which were plugged into a 3-way adapter. At the time of the observation the maintenance director could not explain why the adapters had not been noticed and removed during the quarterly safety 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	B) The maintenance staff will randomly audit resident rooms to ensure 3-ways adapters and in-line surge protectors are not being used. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	