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	01/30/2013

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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 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 fully sprinkled single story building of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with anti-freeze loops and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 91.	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 ceilings were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation on 1/30/13 at 11:32 AM of resident room #147 showed a 2 inch circular penetration in the ceiling. At the time of the observation the environmental services director reported the hole was created when a sprinkler head was moved. He could not explain why the hole had not been noticed and repaired during the monthly safety inspections.	K 012	Ktag 12 Corrective Action: Circular penetration of ceiling hole was fixed on February 12, 2013. ID of Others: An audit of all resident rooms for penetration issues was completed by Maintenance Director / designee completed on or before compliance date. System Measures: Maintenance Director/ designee will do an inspection weekly of resident rooms x4 and then will do random monthly x 2. Maintenance Director/designee will inspect all contractors projects to ensure that no penetration issues were a result of their work. Any issues will be brought to safety committee.	

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

Jennifer Reaume | NHA | 2/25/13

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.

Pc accepted w/ JENNIFER REAUME, NHA, ON 3/7/13.

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K 012	Continued From page 1 Reference, NFPA 101, 2000 Edition; 19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor ...	K 012	Monitoring: Maintenance Director will track and trend safety inspections from The Electronic Life Systems(TELS) program maintenance) and review to see if there is a pattern. This review will be brought to QA&A x3 months to make sure the correct interventions are in place.	
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 2 of 6 smoke barrier walls were smoke resistant. The findings were: 1. Observation on 1/30/13 at 1:56 PM of the attic smoke barrier wall near the kitchen showed a 1 inch unsealed cable penetration. At the time of the observation the environmental services director reported the smoke barrier walls were not routinely inspected to ensure all penetrations were sealed. 2. Observation on 1/30/13 at 2:04 PM of the attic	K 025	Date of Compliance: 03/12/13 Ktag 25 Corrective Action:The attic smoke barrier wall near kitchen was fixed on or before date of compliance. The northwest smoke barrier wall was fixed on or before date of compliance. ID of Others: The maintenance Director/ designee inspected all attic smoke barrier walls on or before date of compliance. System Measures: Maintenance Director/designee will inspect all contractors work after completion to ensure all penetration were sealed. And report any issues to Safety Committee . Maintenance Director/designee will bring to morning meeting Monday thru Friday scheduled safety inspections that follow TELS program weekly x 4 and then randomly x 2 months. Monitoring: Maintenance Director/ designee will track and trend inspections of all contractors and review for patterns. This review will be brought to QAPI committee monthly x3. QAPI	

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K 025	Continued From page 2 northwest smoke barrier wall showed a 1 ½ inch unsealed pipe penetration. At the time of the observation the environmental services director reported the smoke barrier walls were not routinely inspected to ensure all penetrations were sealed.	K 025	committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed,to ensure continued compliance. Date of Compliance: KTag 27	03/12/13
K 027 SS=E	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, the facility failed to ensure 3 of 6 smoke barrier double doors were smoke resistant. The findings were: 1. Observation on 1/30/13 at 10:06 AM of the southwest smoke barrier double doors showed one of the two doors would not latch under the force from the self-closing device. Further observation showed the lower latching rod was removed from one of the doors and the two floor receiving holes were covered up with carpet. At the time of the observation the environmental services director reported the doors were not routinely inspected to ensure the self-closing	K 027	Corrective Action: Southwest smoke barrier doors will be scheduled to be repaired on or before compliance date to return the previous life safety features of the double doors. The Northeast smoke barrier doors will be scheduled for repair to change out latching hardware on or before compliance date. The Southeast smoke barrier doors will be scheduled for repair on or before compliance date. ID of Others: Maintenance Director/designee will complete An audit on or before date of compliance of all smoke barriers double doors. System Measures: Divisional Environmental Service Director/designee will provide education to Environmental Service staff on the importance of routine inspections on smoke barrier doors. Maintenance Director/ designee will audit the routine inspections of the smoke barrier doors following the TELS program.	

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K 027	Continued From page 3 device fully latched the doors into the frame. He also reported he was unaware life safety equipment was required to be maintained to the level it was built to. 2. Observation on 1/30/13 at 11:21 AM of the northeast smoke barrier doors showed the latching hardware was equipped with a locking set screw. Further observation showed the crash bar could be depressed and the set screw would hold the latch in the retracted position. At the time of the observation the environmental services director reported he was unaware a set screw was prohibited on smoke barrier doors. 3. Observation on 1/30/13 at 1:21 PM of the southeast smoke barrier double doors showed one of the two doors would not latch under the force from the self-closing device. At the time of the observation the environmental services director reported the doors were not routinely inspected to ensure the self-closing device fully latched the doors into the frame. 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. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.7.3 Required panic hardware and fire exit hardware shall not be equipped with any locking	K 027	Monitoring : The Maintenance Director/designee will track and trend audits to determine patterns. The results of the reviews will be shared with the QAPI Committee monthly x3. QAPI committee will evaluate the effectiveness of this plan and will imple ment additional interventions as needed, to ensure continued compliance. Date of Compliance:	03/12/13

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K 027	Continued From page 4 device, set screw, or other arrangement that prevents the release of the latch when pressure is applied to the releasing device. Devices that hold the latch in the retracted position shall be prohibited on fire exit hardware unless listed and approved for that purpose.	K 027		
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 1 of 7 fire alarm system components was tested and failed to ensure the central station certificate was current. The findings were: 1. Observationon 1/30/13 at 10:31 AM of the main fire alarm panel showed the central station certificate had expired on 3/31/12. At the time of the observation the environmental service director reported he was unaware the certificate needed to be updated annually. 2. Review of the fire alarm system testing records	K 052	K tag 52 Corrective Action: Central Station certificate was obtained and posted on or before compliance date. The semi-annual load voltage test will be scheduled on or before date of compliance. ID of Others: The Maintenance Director will complete an audit of the testing records of fire control panels to ensure all appropriate tests are done or schedule on or before date of compliance. Systems Measures: Maintenance Director/designee will bring to morning meeting Monday thru Friday the scheduled life safety inspections and will report any issues to Safety Committee.	

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K 052	Continued From page 5 showed the system was last tested on 9/17/12. Further review showed the semi-annual load voltage test had not been performed on the batteries in the fire alarm control panel in the six months prior to the inspection. On 1/30/13 at 3:15 PM the environmental service director reported he was unaware of the aforementioned test. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test ..... annually (Replace batteries every 4 years.) 2. Discharge Test ... ... annually (30 minutes) 3. Load Voltage Test ..... semi-annually	K 052	Monitoring: The maintenance Director will track and trend any issues brought up thru safety inspections to determine the if there is a pattern. The results of this review will be brought to QA&A committee monthly x3. QA& A committee will evaluate the effectiveness of this plan and will implement additional interventions as needed to ensure continued compliance. K tag 62 Corrective Action: The 4 antifreeze branch lines will be maintained with proper anti-freeze solution on or before the date of compliance. A drain valve will be installed at the end of each loop to ensure accurate sample readings. Id of Others: The Maintenance Director/ designee will complete an audit of anti-freeze branch lines on or before date of compliance. System Measures: Maintenance Director/ designee will drain the 4 anti freeze loops to get true reading if anti-freeze solution is not prepared with a freezing point below the expected minimum temperature for locality will be corrected. Maintenance Director/designee will audit future inspections to ensure anti freeze is the appropriate solution for the locality.	03/12/13
K 062 SS=F	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 record review and staff interview, the facility failed to ensure 4 of 4 anti-freeze branch lines were maintained with proper anti-freeze solution. The findings were: Review of the sprinkler system testing records showed the four anti-freeze loops under the exterior canopies did not have a freezing point below the expected minimum temperature for the	K 062		

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K 062	Continued From page 6 locality of the facility. The solutions were +16 degrees at the kitchen, +17 degrees at the dish washing room, +5 degrees at the boiler room, and -2 degrees at the laundry room. Review of actual local low temperatures shows that Cheyenne has seen -15 degrees in 2013 and typically has one or more days at -10 degrees during a winter season, per www.noaa.gov. On 1/30/13 the environmental services director could not explain why the sprinkler contractor had not modified the anti-freeze solution to levels below the expected low temperature. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 4-5.2.3 An anti-freeze solution shall be prepared with a freezing point below the expected minimum temperature for the locality ...	K 062	Monitoring: The Maintenance Director/ designee will track and trend audits determine patterns based in review of records. The result of this review will be shared with the QA&A committee monthly x3. QA&A committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance. Date of Compliance: K tag 64 Corrective Action: The break room Portable fire extinguisher was inspected on or before date of compliance. ID of Others: Maintenance Director/ designee will complete an audit of facility	03/12/13
K 064 SS=D	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, 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 inspected annually in 1 of 7 smoke compartments. The findings were: Observation on 1/30/13 at 1:02 PM of the staff break room showed the last annual inspection of the portable fire extinguisher occurred in August 2011. At the time of the observation the	K 064	fire extinguishers on or before date of compliance. System Measures: Maintenance Director /designee will give a map of the location of facility portable fire extinguishers to the vendor who is doing annual inspection. Maintenance Director/designee will audit for completion of vendor inspection and vendor will make any corrections found. Monitoring: Maintenance Director/designee will track and trend audits, determine patterns based on review of safety inspections to determine completeness. The result of this review will be shared with the QAPI Committee monthly x3. QAPI committee	

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K 064	Continued From page 7 environmental service director could not explain why the extinguisher contractor had not inspected this extinguisher in June 2012 with the rest of the facilities extinguishers. Reference, NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition; 4-4 Maintenance. 4-4.1 Frequency. Fire Extinguishers shall be subjected to maintenance at intervals of not more than 1 year, and the time of hydrostatic test, of when the specifically indicated by an inspection.	K 064	will evaluate the effectiveness of this plan and will implement additional interventions as needed, to ensure continued compliance. Date of Compliance:	03/12/13
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 damaged electrical wiring was modified or replaced in 1 of 7 smoke compartments. The findings were: Observation on 1/30/13 at 11:08 AM of resident room #137 showed the electrical four plex box near bed "B" had pulled away from the wall. Further observation showed electrical wires and connections were exposed with a 1-inch gap between the box and wall. At the time of the observation the environmental service director could not explain why the damaged electrical box was not noticed and repaired during the monthly safety inspections or the daily cleaning of the room. Reference, NFPA 101, 2000 Edition, 19.5.1,	K 147	K tag 147 Corrective Action: The four plex box in room #137 was repaired on 1/30/13. ID of Others: Maintenance Director/ designee will complete an audit of facilities room for electrical boxes that are pulled away from wall on or before the date of compliance. Systems Measures: Maintenance Director/designee will provide education to facility maintenance staff and housekeeping staff to inspect electrical boxes for gaps from the wall in rooms on regular inspections and cleaning of rooms. Maintenance Director/designee will audit facility rooms for electrical boxes pulled away from the wall weekly x4 and than random audits monthly x2. Monitoring: The Maintenance Director/ designee will track and trend audits, determine patterns based on a review to determine inspections are complete. The results of this review will be shared with QA&A Committee monthly x3. QA&A committee will evaluate the effectiveness of this plan and will implement additional	

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K 147	Continued From page 8 9.1.2, NFPA 70, 1999 Edition; 110-27. Guarding of Live Parts. (b) Prevent physical damage. In locations where electric equipment would be exposed to physical damage, enclosure of guards shall be so arranged and of such strength so to prevent such damage.	K 147	interventions, as needed , to ensure continued compliance.	03/12/13