STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE 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
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 sprinklered, three story building of Type II (222) and II (111) construction, with a basement, built in 1966 and 1972, respectively. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 115.	K 000	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that corridor doors are equipped with strike plates and create a positive latch to the door frame. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all double doors create a positive latch to the door frame.	
K 018 SS=E	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	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their routine rounds the inspection of self-closing device doors to confirm they create a positive latch to the door frame.	

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

Executive Director 6/3/13

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.

ACCEPTED/ DAN STACKIS, ED, DN 6/14/13.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 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 sprinklered, three story building of Type II (222) and II (111) construction, with a basement, built in 1966 and 1972, respectively. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 115.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-018: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:**	
K 018 SS=E	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	The Maintenance Director/Designee installed strike plates into the dining room door and confirmed the door creates a positive latch to the door frame. The Maintenance Director/Designee adjusted the rehabilitation gym north entrance door so it creates a positive latch to the door frame.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 on 1 of 4 floors. The findings were: 1. Observation of the dining room on 5/7/13 at 10:01 AM showed the double corridor doors were not equipped with strike plates. The doors were equipped with self-closing devices, but the doors were unable to latch into the door frame. At the time of the observation the maintenance assistant was unaware why the strike plates were not installed. 2. Observation of the rehabilitation gym on 5/7/13 at 10:45 AM showed the north entrance was a set of double doors. Further observation showed one of the doors was unable to remain latched with 5 pounds of pressure applied to the latch side of the door. At the time of the observation the maintenance assistant could not explain why the door was not observed and repaired during the daily door inspections.	K 018	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
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 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	K 029		

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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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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 on 1 of 4 floors. The findings were: 1. Observation of the dining room on 5/7/13 at 10:01 AM showed the double corridor doors were not equipped with strike plates. The doors were equipped with self-closing devices, but the doors were unable to latch into the door frame. At the time of the observation the maintenance assistant was unaware why the strike plates were not installed. 2. Observation of the rehabilitation gym on 5/7/13 at 10:45 AM showed the north entrance was a set of double doors. Further observation showed one of the doors was unable to remain latched with 5 pounds of pressure applied to the latch side of the door. At the time of the observation the maintenance assistant could not explain why the door was not observed and repaired during the daily door inspections.	K 018	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-029: NFPA 101 Life Safety Code Standard	
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 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	K 029		

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K 029	Continued From page 2 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 uses areas on 3 of 4 floors. The findings were: 1. Observation of the clean linen room near resident room #114 on 5/7/13 at 10:52 AM showed there were two unsealed conduit penetrations above the circuit panel. The largest gap measured 2 inches across. At the time of the observation the maintenance assistant could not explain why the holes had not been noticed and repaired during the monthly safety inspections. 2. Observation of the housekeeping floor buffer storeroom on 5/7/13 at 11:36 AM showed the door was not able to be fully latched into the door frame, with the power from the installed self-closing device. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections. 3. Observation of the basement housekeeping paper storeroom on 5/7/13 at 11:38 AM showed paper products had recently been stored in this room that was greater than 50 square feet. Further observation showed a self-closing device had not been added to the double corridor doors. At the time of the observation the maintenance assistant reported he was unaware self-closing devices were required on storerooms.	K 029	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee sealed the conduit penetrations in the clean linen room near resident room #114 with approved fire-rated material. The Maintenance Director/Designee repaired the housekeeping floor buffer storeroom door to confirm that it fully latches to the door frame. The Maintenance Director/Designee installed a self-closing device on the double corridor doors located in the housekeeping paper storeroom. The Maintenance Director/Designee repaired the door of the clean linen room near resident room #310 so it fully latched to the door frame.	

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K 029	Continued From page 2 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 uses areas on 3 of 4 floors. The findings were: 1. Observation of the clean linen room near resident room #114 on 5/7/13 at 10:52 AM showed there were two unsealed conduit penetrations above the circuit panel. The largest gap measured 2 inches across. At the time of the observation the maintenance assistant could not explain why the holes had not been noticed and repaired during the monthly safety inspections. 2. Observation of the housekeeping floor buffer storeroom on 5/7/13 at 11:36 AM showed the door was not able to be fully latched into the door frame, with the power from the installed self-closing device. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections. 3. Observation of the basement housekeeping paper storeroom on 5/7/13 at 11:38 AM showed paper products had recently been stored in this room that was greater than 50 square feet. Further observation showed a self-closing device had not been added to the double corridor doors. At the time of the observation the maintenance assistant reported he was unaware self-closing devices were required on storerooms.	K 029	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm conduit penetrations have been sealed. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all self-closing device doors appropriately latch to the door frame. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will inspect twenty-five percent (25%) of the facility on a quarterly basis to confirm that conduit penetrations are sealed. The Maintenance Director/Designee will incorporate into their quarterly rounds the inspection of doors with self-closing devices to confirm that the doors will appropriately latch to the door frame.	

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K 029	Continued From page 3 4. Observation of the clean linen room near resident room #310 on 5/7/13 at 1:56 PM showed the door was not able to be fully latched into the door frame with the power from the self-closing device. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections.	K 029	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 6 exits doors did not require excessive force to open. The findings were: Observation of the transitional care unit northeast exit double doors on 5/7/13 at 11:18 AM showed one of the two exit doors required excessive force to open. The aluminum door was rubbing against the floor threshold. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf	K 038	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-38: NFPA 101 Life Safety Code Standard	

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K 029	Continued From page 3 4. Observation of the clean linen room near resident room #310 on 5/7/13 at 1:56 PM showed the door was not able to be fully latched into the door frame with the power from the self-closing device. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections.	K 029	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee repaired the transitional care unit northeast exit door so it does not require excessive force and does not rub against the floor threshold. The threshold was repaired on May 10, 2013.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 6 exits doors did not require excessive force to open. The findings were: Observation of the transitional care unit northeast exit double doors on 5/7/13 at 11:18 AM showed one of the two exit doors required excessive force to open. The aluminum door was rubbing against the floor threshold. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf	K 038	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm all exit doors open without excessive force and appropriately.	

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K 029	Continued From page 3 4. Observation of the clean linen room near resident room #310 on 5/7/13 at 1:56 PM showed the door was not able to be fully latched into the door frame with the power from the self-closing device. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 6 exits doors did not require excessive force to open. The findings were: Observation of the transitional care unit northeast exit double doors on 5/7/13 at 11:18 AM showed one of the two exit doors required excessive force to open. The aluminum door was rubbing against the floor threshold. At the time of the observation the maintenance assistant could not explain why the door had not been noticed and repaired during the monthly safety inspections. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf	K 038	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into their quarterly rounds on a facility-wide basis an audit to confirm that exit doors open without excessive force and appropriately. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	

C

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K 038	Continued From page 4 (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038		
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. This STANDARD is not met as evidenced by: Based on records review, observation and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: 1. Review of the emergency battery light testing records showed there were no 30 second monthly records to review. Further review showed there were no 90 minute annual test records to review. On 5/1/13 at 2:40 PM the maintenance assistant could not explain why the tests were not performed. 2. Review of the emergency generator testing records showed the only records to review where for the dates of 3/13/13 and 2/20/13. On 5/7/13 at 10:10 AM the executive director reported a new temporary generator was installed the week of 4/1/13 because of excessive oil leakage during the annual load bank test. The facility did not have record of the weekly exercise for the past two years. At 10:10 AM the executive director reported the previous maintenance director removed all of the past records. He could not	K 046	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-046: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will conduct a 30 second monthly battery test and a 90 minute annual battery test.	

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K 038	Continued From page 4 (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038		
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. This STANDARD is not met as evidenced by: Based on records review, observation and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: 1. Review of the emergency battery light testing records showed there were no 30 second monthly records to review. Further review showed there were no 90 minute annual test records to review. On 5/1/13 at 2:40 PM the maintenance assistant could not explain why the tests were not performed. 2. Review of the emergency generator testing records showed the only records to review where for the dates of 3/13/13 and 2/20/13. On 5/7/13 at 10:10 AM the executive director reported a new temporary generator was installed the week of 4/1/13 because of excessive oil leakage during the annual load bank test. The facility did not have record of the weekly exercise for the past two years. At 10:10 AM the executive director reported the previous maintenance director removed all of the past records. He could not	K 046	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct ongoing audits to confirm the completion of the 30 second monthly testing and the 90 minute annual testing of the emergency battery light system.	

B

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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 038	Continued From page 4 (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038		
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. This STANDARD is not met as evidenced by: Based on records review, observation and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: 1. Review of the emergency battery light testing records showed there were no 30 second monthly records to review. Further review showed there were no 90 minute annual test records to review. On 5/1/13 at 2:40 PM the maintenance assistant could not explain why the tests were not performed. 2. Review of the emergency generator testing records showed the only records to review where for the dates of 3/13/13 and 2/20/13. On 5/7/13 at 10:10 AM the executive director reported a new temporary generator was installed the week of 4/1/13 because of excessive oil leakage during the annual load bank test. The facility did not have record of the weekly exercise for the past two years. At 10:10 AM the executive director reported the previous maintenance director removed all of the past records. He could not	K 046	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will conduct ongoing audits of the preventative maintenance program to confirm the completion of the required tests addressing the emergency battery light system. Copies of supporting documentation will be maintained by the Executive Director/Designee.	

C

NT OF HEALTH AND HUMAN SERVICES
OR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 038	Continued From page 4 (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038		
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. This STANDARD is not met as evidenced by: Based on records review, observation and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: 1. Review of the emergency battery light testing records showed there were no 30 second monthly records to review. Further review showed there were no 90 minute annual test records to review. On 5/1/13 at 2:40 PM the maintenance assistant could not explain why the tests were not performed. 2. Review of the emergency generator testing records showed the only records to review where for the dates of 3/13/13 and 2/20/13. On 5/7/13 at 10:10 AM the executive director reported a new temporary generator was installed the week of 4/1/13 because of excessive oil leakage during the annual load bank test. The facility did not have record of the weekly exercise for the past two years. At 10:10 AM the executive director reported the previous maintenance director removed all of the past records. He could not	K 046	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will conduct ongoing audits of the preventative maintenance program to confirm the completion of the required tests addressing the emergency battery light system. The Maintenance Director/Designee will conduct weekly 15 minute generator exercise tests and a 30 minute monthly generator load test. Copies of supporting documentation will be maintained by the Executive Director/Designee.	

D

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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/19/13

(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 046	Continued From page 5 explain why the weekly exercises were not being performed. Reference NFPA 101, 2000 Edition, 21.2.9.1; 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems. 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 1-1/2 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 the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
K 050 SS=C	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	K 050	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-050: NFPA 101 Life Safety Code Standard	

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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 050	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on records review and staff interview, the facility failed to ensure fire drill records were maintained for 3 of the past 4 quarters. The findings were: Review of the fire drill records showed there was not a record of a fire drill being performed on the second and third shifts during the second and third quarters of 2012. On 5/7/13 at 3:50 PM the executive director reported the previous maintenance director removed the fire drill records for the past two years. Facility policy indicates a fire drill is to be held on each shift on a monthly basis. Interview with the third floor charge nurse on 5/7/13 at 4:03 PM indicated a fire drill was held on each shift on a monthly basis.	K 050	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will conduct fire drills in accordance with, or exceeding, NFPA 101 Life Safety Code Standard regulations. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct fire drills in accordance with, or exceeding, NFPA 101 Life Safety Code Standard regulations.	
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	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 050	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on records review and staff interview, the facility failed to ensure fire drill records were maintained for 3 of the past 4 quarters. The findings were: Review of the fire drill records showed there was not a record of a fire drill being performed on the second and third shifts during the second and third quarters of 2012. On 5/7/13 at 3:50 PM the executive director reported the previous maintenance director removed the fire drill records for the past two years. Facility policy indicates a fire drill is to be held on each shift on a monthly basis. Interview with the third floor charge nurse on 5/7/13 at 4:03 PM indicated a fire drill was held on each shift on a monthly basis.	K 050	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will conduct ongoing audits to confirm the completion of fire drills in accordance with, or exceeding, NFPA 101 Life Safety Code regulations. Copies of supporting documentation will be maintained by the Executive Director/Designee.	
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	K 052		

B

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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

(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 050	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on records review and staff interview, the facility failed to ensure fire drill records were maintained for 3 of the past 4 quarters. The findings were: Review of the fire drill records showed there was not a record of a fire drill being performed on the second and third shifts during the second and third quarters of 2012. On 5/7/13 at 3:50 PM the executive director reported the previous maintenance director removed the fire drill records for the past two years. Facility policy indicates a fire drill is to be held on each shift on a monthly basis. Interview with the third floor charge nurse on 5/7/13 at 4:03 PM indicated a fire drill was held on each shift on a monthly basis.	K 050	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
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	K 052		

C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

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K 050	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on records review and staff interview, the facility failed to ensure fire drill records were maintained for 3 of the past 4 quarters. The findings were: Review of the fire drill records showed there was not a record of a fire drill being performed on the second and third shifts during the second and third quarters of 2012. On 5/7/13 at 3:50 PM the executive director reported the previous maintenance director removed the fire drill records for the past two years. Facility policy indicates a fire drill is to be held on each shift on a monthly basis. Interview with the third floor charge nurse on 5/7/13 at 4:03 PM indicated a fire drill was held on each shift on a monthly basis.	K 050		
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	K 052	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-052: NFPA 101 Life Safety Code Standard	

D

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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

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K 052	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure smoke detectors were maintained on 1 of 3 floors, failed to ensure a current central station certificate was posted and failed to ensure the fire alarm system was tested on an annual basis. The findings were: 1. Observation of the beauty shop on 5/7/13 at 10:06 AM showed the smoke detector was hanging from the power supply wires and disconnected from the unit base. At the time of the observation the maintenance assistant could not explain why the smoke detector had not been noticed and repaired during the monthly safety inspections. 2. Observation of the central station certificate on 5/7/13 at 10:35 AM showed it had expired on 3/31/13. At the time of the observation the maintenance assistant could not explain why the certificate was not replaced after the expiration date. 3. Review of the fire alarm system annual testing records showed the system was last tested more than one year ago. The system was last tested on 2/13/12. On 5/7/13 at 4:35 PM the executive director reported the system was not scheduled because of maintenance staff turnover. 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	K 052	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will replace the smoke detector in the beauty shop. The Maintenance Director/Designee will obtain an active/current central station certification. The Maintenance Director/Designee will have an annual test conducted on the fire alarm system. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that smoke detectors are in appropriate working order and condition.	

A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

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K 052	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure smoke detectors were maintained on 1 of 3 floors, failed to ensure a current central station certificate was posted and failed to ensure the fire alarm system was tested on an annual basis. The findings were: 1. Observation of the beauty shop on 5/7/13 at 10:06 AM showed the smoke detector was hanging from the power supply wires and disconnected from the unit base. At the time of the observation the maintenance assistant could not explain why the smoke detector had not been noticed and repaired during the monthly safety inspections. 2. Observation of the central station certificate on 5/7/13 at 10:35 AM showed it had expired on 3/31/13. At the time of the observation the maintenance assistant could not explain why the certificate was not replaced after the expiration date. 3. Review of the fire alarm system annual testing records showed the system was last tested more than one year ago. The system was last tested on 2/13/12. On 5/7/13 at 4:35 PM the executive director reported the system was not scheduled because of maintenance staff turnover. 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	K 052	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will conduct ongoing audits to confirm that smoke detectors are in appropriate working order and condition. The Maintenance Director/Designee will confirm that the central station certificate remains current. The Maintenance Director/Designee will confirm the annual testing of the fire alarm system is part of the preventative maintenance program and acted upon.	

B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE 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
K 052	Continued From page 8 d. Sealed Lead-Acid Type 1. Charge Test,.....annually (Replace batteries every 4 years.), 2. Discharge Test (30 minutes) ... ...annually 3. Load Voltage Test,.....semi-annually 14. Remote Annunciator,.....annually 15. Initiating Devices a. Duct Detectors,.....annually b. Electromechanical Releasing Device (Smoke Dampers), ...annually e. Heat Detectors,.....annually f. Fire Alarm Boxes,.....annually h. All Smoke Detectors,.....annually 19. Alarm Notification Appliances a. Audible Devices,.....annually c. Visible Devices,.....annually	K 052	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
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 sprinkler heads had the same activation response time in continuous compartments, failed to ensure sprinkler piping was installed to manufacturers recommendations, and failed to ensure sprinkler heads were installed no more than 12 inches from the ceiling on 3 of 4 floors. The findings were: 1. Observation of the main dining room on 5/7/13	K 062	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-062: NFPA 101 Life Safety Code Standard	

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	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE 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
K 062	Continued From page 9 at 9:37 AM showed five of nine sprinkler heads had been replaced with quick response 150 degree pendent sprinkler heads. At the time of the observation the maintenance assistance could not explain why the installing contractor had not replaced all of the sprinkler heads in the compartment with quick response heads. He confirmed that he was unaware of the aforementioned requirement and assumed the contractor would install new heads in accordance with NFPA 13. 2. Observation of the sprinkler system on 5/7/13 between 10 AM and 2 PM showed the sprinkler pipes in the activities office and hopper closet near resident room #227 were orange CPVC pipe. Further observation showed these pipes were not installed directly against the building surface. The pipes were installed between 6 and 18 inches below the ceiling. On 5/7/13 at 10:21 AM the maintenance assistance could not explain why the sprinkler contractor had not installed the sprinkler pipe against the ceiling per the manufacturer ' s recommendations. He also reported the facility did not have plans to shield or encase the pipes for protection of potential heat of fire. 3. Observation of the transitional care unit on 5/7/13 between 11AM and 11:30 AM showed sprinkler had been added to the resident room closets. Further observation showed the ceilings had not been installed in 11 closets. The sprinkler heads were located more than the allowed 12 inches below the roof because of the lack of the ceiling. On 5/7/13 at 11:20 the executive director reported the sprinkler heads were installed and functional in February 2013. He reported the	K 062	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will install four (4) quick response sprinkler heads in the dining room. These sprinkler heads were installed on May 10, 2013. The Maintenance Director/Designee will place the sprinkler pipes located in the Activities Office and hopper closet near resident room #227 against the building surface. The Maintenance Director/Designee will install the ceilings in resident room closets located in the transitional care unit.	

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	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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(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 062	Continued From page 9 at 9:37 AM showed five of nine sprinkler heads had been replaced with quick response 150 degree pendent sprinkler heads. At the time of the observation the maintenance assistance could not explain why the installing contractor had not replaced all of the sprinkler heads in the compartment with quick response heads. He confirmed that he was unaware of the aforementioned requirement and assumed the contractor would install new heads in accordance with NFPA 13. 2. Observation of the sprinkler system on 5/7/13 between 10 AM and 2 PM showed the sprinkler pipes in the activities office and hopper closet near resident room #227 were orange CPVC pipe. Further observation showed these pipes were not installed directly against the building surface. The pipes were installed between 6 and 18 inches below the ceiling. On 5/7/13 at 10:21 AM the maintenance assistance could not explain why the sprinkler contractor had not installed the sprinkler pipe against the ceiling per the manufacturer ' s recommendations. He also reported the facility did not have plans to shield or encase the pipes for protection of potential heat of fire. 3. Observation of the transitional care unit on 5/7/13 between 11AM and 11:30 AM showed sprinkler had been added to the resident room closets. Further observation showed the ceilings had not been installed in 11 closets. The sprinkler heads were located more than the allowed 12 inches below the roof because of the lack of the ceiling. On 5/7/13 at 11:20 the executive director reported the sprinkler heads were installed and functional in February 2013. He reported the	K 062	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all sprinkler heads in a given smoke compartment are uniform. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that sprinkler heads are placed the appropriate distance from the building surface. The Maintenance Director/Designee will conduct a facility-wide audit to confirm all resident closets have appropriate ceilings.	

B

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K 062	Continued From page 9 at 9:37 AM showed five of nine sprinkler heads had been replaced with quick response 150 degree pendent sprinkler heads. At the time of the observation the maintenance assistance could not explain why the installing contractor had not replaced all of the sprinkler heads in the compartment with quick response heads. He confirmed that he was unaware of the aforementioned requirement and assumed the contractor would install new heads in accordance with NFPA 13. 2. Observation of the sprinkler system on 5/7/13 between 10 AM and 2 PM showed the sprinkler pipes in the activities office and hopper closet near resident room #227 were orange CPVC pipe. Further observation showed these pipes were not installed directly against the building surface. The pipes were installed between 6 and 18 inches below the ceiling. On 5/7/13 at 10:21 AM the maintenance assistance could not explain why the sprinkler contractor had not installed the sprinkler pipe against the ceiling per the manufacturer ' s recommendations. He also reported the facility did not have plans to shield or encase the pipes for protection of potential heat of fire. 3. Observation of the transitional care unit on 5/7/13 between 11AM and 11:30 AM showed sprinkler had been added to the resident room closets. Further observation showed the ceilings had not been installed in 11 closets. The sprinkler heads were located more than the allowed 12 inches below the roof because of the lack of the ceiling. On 5/7/13 at 11:20 the executive director reported the sprinkler heads were installed and functional in February 2013. He reported the	K 062	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into the preventative maintenance program routine rounds to confirm all sprinkler heads are uniform within a smoke compartment and that all sprinkler heads are placed the appropriate distance from the building surface. The Maintenance Director/Designee will place into the preventative maintenance program an inspection to confirm that ceilings are present in all closets.	

C

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K 062	Continued From page 10 ceilings had not been installed three months after the installation was completed, because of maintenance turnover. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-3.5 Other types of pipe or tube investigated for suitability in automatic sprinkler installations and listed for this service, including but not limited to polybutylene, CPVC, and steel differing from that provided in Table 3-3.5 shall be permitted where installed in accordance with their listing limitations, including installation instructions ... Harvel Blazemaster manufactures installation guide stated " Pendent Sprinklers Light Hazard or Residential Pendent Sprinklers ...The piping shall be mounted directly to the ceiling " . 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed. 5-6.4.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. and a maximum of 12 in.	K 062	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not	K 066	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-066: NFPA 101 Life Safety Code Standard	

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K 066	Continued From page 11 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoking area was maintained cleaned and safe ashtrays were available. The findings were: Observation of the courtyard smoking area on 5/7/13 at 10:42 AM showed numerous cigarette butts were in the trash can. Further observation showed cigarette butts were in many of the corners of the courtyard mingled with dry leaves. Observation of two of the self-snuffing ashtrays showed the inner buckets were over flowing with cigarette butts. At the time of the observation the maintenance assistance could not explain why the ashtrays had not been cleaned out and the entire area maintained free of cigarette butts. He could not verify if the cigarette butts in the corners were blown out of the trash can or thrown there by staff or residents.	K 066	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee cleaned the resident smoking area, emptied the trash cans, and emptied the self-snuffing ashtrays. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm cigarettes are cleaned up, trash cans are emptied, and self-snuffing ashtrays are emptied.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 066	Continued From page 11 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoking area was maintained cleaned and safe ashtrays were available. The findings were: Observation of the courtyard smoking area on 5/7/13 at 10:42 AM showed numerous cigarette butts were in the trash can. Further observation showed cigarette butts were in many of the corners of the courtyard mingled with dry leaves. Observation of two of the self-snuffing ashtrays showed the inner buckets were over flowing with cigarette butts. At the time of the observation the maintenance assistance could not explain why the ashtrays had not been cleaned out and the entire area maintained free of cigarette butts. He could not verify if the cigarette butts in the corners were blown out of the trash can or thrown there by staff or residents.	K 066	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into the preventative maintenance program the routine inspection of the resident smoking area to confirm that cigarette butts are cleaned up, trash cans are emptied, and self-snuffing ashtrays are emptied.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 066	Continued From page 11 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoking area was maintained cleaned and safe ashtrays were available. The findings were: Observation of the courtyard smoking area on 5/7/13 at 10:42 AM showed numerous cigarette butts were in the trash can. Further observation showed cigarette butts were in many of the corners of the courtyard mingled with dry leaves. Observation of two of the self-snuffing ashtrays showed the inner buckets were over flowing with cigarette butts. At the time of the observation the maintenance assistance could not explain why the ashtrays had not been cleaned out and the entire area maintained free of cigarette butts. He could not verify if the cigarette butts in the corners were blown out of the trash can or thrown there by staff or residents.	K 066	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	Continued From page 12 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure oxygen cylinders were restrained on 1 of 4 floors. The findings were: Observation of the first floor oxygen storeroom on 5/7/13 at 10:59 AM showed two oxygen cylinders were not restrained. At the time of the observation the maintenance assistance could not explain why nursing staff had not restrained the cylinders.	K 076	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-076: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will restrain all oxygen cylinders in the first floor oxygen storeroom.	
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 ensure junction boxes were provided with covers, failed to ensure electrical	K 147		

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K 076	Continued From page 12 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure oxygen cylinders were restrained on 1 of 4 floors. The findings were: Observation of the first floor oxygen storeroom on 5/7/13 at 10:59 AM showed two oxygen cylinders were not restrained. At the time of the observation the maintenance assistance could not explain why nursing staff had not restrained the cylinders.	K 076	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all oxygen cylinders are restrained in all oxygen storerooms.	
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 ensure junction boxes were provided with covers, failed to ensure electrical	K 147		

B

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K 076	Continued From page 12 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure oxygen cylinders were restrained on 1 of 4 floors. The findings were: Observation of the first floor oxygen storeroom on 5/7/13 at 10:59 AM showed two oxygen cylinders were not restrained. At the time of the observation the maintenance assistance could not explain why nursing staff had not restrained the cylinders.	K 076	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into the preventative maintenance program routine audits to confirm that all oxygen cylinders are restrained in all oxygen rooms. The Maintenance Director/Designee will provide education to nursing staff regarding the appropriate method to restrain all oxygen cylinders stored in oxygen storerooms. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:**	
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 ensure junction boxes were provided with covers, failed to ensure electrical	K 147	The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	

C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 076	Continued From page 12 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure oxygen cylinders were restrained on 1 of 4 floors. The findings were: Observation of the first floor oxygen storeroom on 5/7/13 at 10:59 AM showed two oxygen cylinders were not restrained. At the time of the observation the maintenance assistance could not explain why nursing staff had not restrained the cylinders.	K 076		
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 ensure junction boxes were provided with covers, failed to ensure electrical	K 147	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-147: NFPA 101 Life Safety Code Standard	

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6/14/13

(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 147	Continued From page 13 panels had adequate work space, failed to ensure temporary electrical adapters did not replace permanent fixed wiring, and failed to ensure damaged electrical equipment was replaced on 3 of 4 floors. The findings were: 1. Observation of the electrical equipment on 5/7/13 between 9:30 AM and 12 PM showed the junction box cover was missing in the kitchen dish washing room under the garbage disposal and in the HVAC room. The missing covers allowed electrical wire nuts to be exposed. On 5/7/13 at 9:42 AM the maintenance assistant reported the electrical system was not routinely inspected to ensure junction box covers were in place. 2. Observation of the electrical system on 5/7/13 between 11 AM and 12 PM showed electrical panels in the transitional care unit nurse manager's office and generator room were impeded by carts and cardboard boxes. On 5/7/13 at 11:13 AM the maintenance assistant could not explain why the items were stored in front of the electrical panels. He further reported that all staff have been trained to not obstructed electrical panels. 3. Observation of the electrical system on 5/7/13 between 1 PM the 2 PM showed the following location had temporary electrical adapters replacing permanent fixed wiring: a. The fan in resident room #202 was plugged into and extension cord which was plugged into a surge protector. b. The computer in the second floor unit manager's office was plugged into a surge protector which was plugged into an extension	K 147	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director/Designee will place covers on the junction boxes located in the kitchen dish room and HVAC room. The Maintenance Director/Designee removed the carts from near the electrical panels in the transitional care unit nurse manager's office and generator room. The Maintenance Director/Designee removed the extension cord in room #202 and in the second floor nurse manager's office. The Maintenance Director/Designee repaired the face plate in room #305. This was completed on May 8, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

6/14/13

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K 147	Continued From page 14 cord. On 5/7/13 at 1:09 PM the maintenance assistant could not explain why the electrical adapter had not been noticed and removed during the monthly safety inspections. 4. Observation of resident room #305 on 5/7/13 at 1:51 PM showed the face plate of the electrical outlet near bed " B " was damaged, which allowed wires to be exposed. At the time of the observation the maintenance assistant could not explain why the face plate had not been noticed and replaced during the monthly safety inspections. Reference NFPA 101, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 90-7 Examination of Equipment for Safety. ...It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations of damage ... 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment... (a) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of (1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of access to live parts shall not be less than indicated in table 110-26(a) ...	K 147	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all junction boxes have covers. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all electrical panels are not impeded. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that extension cords are not being used. The Maintenance Director/Designee will conduct a facility-wide audit to confirm that face plates are not damaged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 15 Table 110-26(a) Nominal Voltage To Ground — Minimum Clear Distance (ft) 0/150 — 3 ft. (b) Clear Space. Working space required by this section shall not be used for storage ... 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	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director/Designee will incorporate into the preventative maintenance program audits to confirm that junction boxes have covers, electrical panels are not impeded, extension cords are not being used, and that face plates are not damaged. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Maintenance Director/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is June 23, 2013.	