DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2010
FORM APPROVED
OMB NO. 0938-0391

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 _____	01/25/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with four anti-freeze loops under exterior canopies and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K 018** **1. Oil was added to door closer and adjustments were made to the strike plate .** 2.All doors protecting corridor openings were checked. Employee break room was found to have a defective closer and was replaced. 3. All corridor doors to be audit Weekly to ensure proper functioning per our Plan Maintenance Program (TELS). 4.Results from the TELS program will be brought monthly to QA&A meeting for 3 months for review and recommendations then will be reassess the need for Continued monitoring based on Compliance. 5.Compliance Date:	3/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume — TITLE: NHA — (X6) DATE: 2-22-10

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EXNN21 Facility ID: WY0005 If continuation sheet Page 1 of 6

Wyoming Dept of Health

FEB 22 2010

Office of Healthcare Licensing and Surveys

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation on 1/25/10 at 10:52 AM showed the corridor door to the restorative dining room was equipped with an automatic closing device that did not fully latch into its frame. Observation also showed the latch bolt did not insert into the strike plate when the door was pulled closed. At the time of observation the maintenance director reported all corridor doors were inspected quarterly to ensure they latched properly.	K 018	K029 1. The Central Supply Cart blocking the egress was removed. A new central supply cart was ordered and is stored in North nurses supply room. 2. An audit of all exit doors was completed and no other issues were identified. 3. Weekly rounds are done by Maintenance Director /designees of all exit doors and will be added to log book. 4. Results from weekly rounds will be brought to monthly QA&A meeting for review for 3 months and then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
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 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were:	K 029		

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K 029	Continued From page 2 Observation on 1/25/10 at 11:45 AM showed a six foot tall linen cart was stored in the hallway next to central supply. At the time of observation a nurse reported the cart was stored at this location except at shift change when restocking disposable briefs and bandage type supplies. The housekeeping supervisor reported she was aware the cart was not to be stored in the hallway off the corridor. She further reported the cart was too large to be stored in the nursing supply closet.	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 delayed egress locks on exit doors released within 15 seconds in 2 of 6 smoke compartments. The findings were: Observation on 1/25/10 between 10 AM and 11 AM showed the delayed egress locks attached to the southwest and southeast exit doors did not release within 15 seconds when pressure was applied to the doors. Despite the pressure that was applied for more than 30 seconds, the doors did not release. At the time of observation the maintenance director was able to release each door by entering a code into the key pad. He stated that he was not aware the doors were supposed to release when pressure was applied.	K 038	**K 038** **1.The delayed egress locks on southeast and southwest doors were adjusted immediately to release within 15 seconds.** 2.An audit of all doors that had Delayed egress lock on them was completed and no issues were identified. 3.Delayed egress locks are check Daily Per TELS PMP. By maintenance director or designee any issues identified will be corrected. 4. Results from TELS will Be brought to monthly QA&A Meeting for 3 months for review and recommendations, then reassess the need for continued monitoring based on compliance. 5.Compliance Date	03/2/10
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050 SS=F	Continued From page 3 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure fire drills were conducted at varying times on 2 of 3 shifts. The findings were: Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM and the second shift occurred between 2 PM and 10 PM. Further review documented the fire drills conducted on the first shift during the second, third and fourth quarters of 2009 all occurred between 10 AM and 10:20 AM. Records also documented the fire drills conducted on the second shift during all four quarters of 2009 had occurred between 2:10 PM and 3:30 PM. On 1/25/10 at 1:40 PM the maintenance director reported he was unaware that fire drills were required to be conducted at varying times throughout each shift.	K 050	K050 1. Fire Drill was done 2/12/10 7:50 am. 2. All fire drills going forward . 3. Maintenance Director /designee will vary times and conditions of fire drills 4. Results from the yearly fire drills will be brought to QA& A meeting for review for 3 months and then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
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	K 062		

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K 062	Continued From page 4 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 sprinklers were unobstructed in 2 of 6 smoke compartments. The findings were: Observation on 1/25/10 between 11 AM and 12 PM showed the sprinklers in the north nursing supply room and resident room #50 were obstructed by ceiling-mounted lights. The sprinklers were installed within 12 inches of the lights, and the bottom of the lights were below the level of the sprinkler deflector. At the time of observation the maintenance director reported he was aware of the spacing requirement. He further reported that the sprinkler system was inspected annually to ensure the sprinklers were not obstructed. He could not explain why these heads had not been detected.	K 062	K062 1. Sprinkler heads in north nursing supply room and resident room # 50 were replaced so that ceiling mounted lights doesn't obstruct them. 2. An annual audit of all sprinkler heads were done by contractor all other sprinkler heads checked. 2 other sprinkler heads found and was repaired. 3. Sprinkler heads will be checked monthly per TELS PMP and any identified issues will be corrected. 4. Results from the TELS will be brought to monthly QA&A meeting for 3 months for review and recommendations, then reassess the need for continued monitoring based on compliance Compliance Date: 3/2/10	
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 damaged electrical equipment was replaced and failed to ensure temporary wiring did not replace permanent fixed wiring in 2 of 6 smoke compartments. The findings were:	K 147		

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K 147	Continued From page 5 1. Observation on 1/25/10 at 10:17 AM showed the electrical receptacle near the bed in resident room #17 was missing half of the face surface. At the time of observation the maintenance director reported the electrical system was inspected monthly. He further reported the nursing staff should have noticed the damaged receptacle and submitted a work order to get it fixed. 2. Observation on 1/25/10 at 11:35 AM showed the scanner in the medical records office was plugged into an existing surge protector that was plugged into a second surge protector. At the time of observation the maintenance director reported he was aware surge protectors were not to be daisy-chained.	K 147	K 147 **1.The electrical receptacle face surface was replaced in room #17. Old surge protector in medical records was removed and installed a new surge protector.** 2.An initial audit of all electrical wiring and equipment was done. Surge protector in admissions office was removed. All damaged face surfaces of electrical receptacle were identified and replaced. 3. a. Re-educate department heads and staff of reporting damaged electrical receptacle face surfaces and the correct use of surge protectors. b. Electrical Receptacles face surface and extension cords or improper use of surge protectors will be audit weekly by maintenance director or designee 4. Results from audits will Be brought to monthly QA&A Meeting for 3 months for review and recommendations, then reassess the need for continued monitoring based on compliance. 5. Compliance Date	3/2/10