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

PRINTED: 12/23/2013
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
	535032	A. BUILDING 01 B. WING	12/17/2013

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

(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, New and Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building (of Type V (111) construction) separated by five, 2-hour rated fire barrier walls with plan approval in 1987 and 2008. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 160 certified Medicare and Medicaid beds with a census of 136 residents.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure the doors in 1 of 5 fire barriers was smoke resistant. The findings were: Observations of the 500 hall cross corridor fire doors on 12/16/13 at 2:02 PM, showed the doors would not fully close and create a smoke resistant	K 011	K011 The facility will ensure that fire barrier double doors were maintained and smoke resistant. This will be accomplished by: A) The 500 hall cross corridor fire doors were adjusted to close properly on 12/18/13. B) Maintenance staff will audit corridor fire double doors to ensure proper latching occurs. Any problems will be immediately repaired or replaced. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	2/1/14

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

By [signature] Executive Director 1/15/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC ACCEPTED W/ BRIAN MORRIS, ED, ON 1/24/14.

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K 011	Continued From page 1 partition. Further observation showed the meeting edges of the doors would bind and prevent a complete seal. At the time of the observation, the maintenance director reported the doors must have been damaged during the recent remodel, because they closed properly during the previous quarterly safety inspection.	K 011		
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 facility staff interview, the facility failed to ensure hazardous areas were separated from uses areas in 3 of 7 smoke compartments. The findings were: 1. Observation of the copier room on 12/16/13 at 11:57 AM, showed there were eleven cardboard copier paper boxes stored in the room. Further observation showed the room was not separated from the administration hallway by a door. At the time of the observation, the maintenance director reported he was unaware this quantity of paper was deemed a hazard and required separation	K 029	K029 The facility will ensure hazardous areas are separated from uses areas. This will be accomplished by: A) All cardboard copier paper boxes were removed from the copier room except two on 12/18/13. All cardboard file boxes filled with paper were removed from the business office and sent to off-site storage on 1/6/14. Combustible items stored in therapy store room were removed on 12/18/13. The 200 hall soiled utility room door was replaced on 12/20/13. B) The maintenance staff will quarterly observe offices, copy rooms, and storage rooms to ensure quantities of combustible materials deemed hazardous are separated from use areas. The maintenance staff will quarterly observe corridor room doors and if a door fails to securely close, maintenance will immediately adjust doors and latches to ensure the doors close securely.	2/1/14

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K 029	Continued From page 2 from use areas. 2. Observation of the business office on 12/16/13 at 12:03 PM, showed there were 18 cardboard file boxes filled with paper. Further observation showed the corridor door was not equipped with a self-closing door. At the time of the observation, the maintenance director reported he was unaware this quantity of paper was deemed a hazard and required separation from use areas. 3. Observation of the therapy storeroom on 12/16/13 at 2:29 PM, showed combustible items were stored on four shelves that were 6 feet tall. The room measured 11 feet by 12 feet for an area of 132 square feet. Further observation showed the door was not equipped with a self-closing devise. At the time of the observation, the therapy manager reported this room had extra stored material because the census was down due to the remodeled rooms. 4. Observation of the 200 hall soiled utility room on 12/16/13 at 3:32 PM, showed the corridor door was not able to fully latch into the door frame because the door had been damaged. The door would bind in the door frame and leave a 4 inch wide gap between the latch side of the door and door frame. Three collection tubs with a capacity of 35 gallons were stored in the room. At the time of the observation, the maintenance director reported the door was damaged two days previously. A new door was on order but the staff was unsure when it would be delivered.	K 029	C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
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	K 038	K038 The facility will ensure that exit discharge pathways are maintained	2/1/14

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K 038	Continued From page 3 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure 2 of 9 exit discharge pathways were maintained unobstructed and failed to ensure 2 of 9 exit doors did not require special knowledge and only required one action to release. The findings were: 1. Observation on 12/16/13 between 12:30 PM and 4:30 PM, showed the dining room and 200 hall exit discharge pathways were obstructed with snow drifts. The largest drift measured 6 feet in length and 4 inches deep. On 12/16/13 at 12:55 PM, the maintenance director reported the wind frequently caused snow to drift. He could not explain why the egress pathways were not monitored each morning to ensure the pathways were unobstructed. 2. Observation of the main entrance door on 12/16/13 at 11:20 AM, showed the door was locked preventing immediate exiting from the building. A sign is posted on the door that reads "To Exit, please enter the code on the key pad and take a step back". The access code is posted on the top of the door frame and is 1 inch long and ½ inch wide. Once the access code had been found and entered into the key pad, the exiting occupant must step back to activate the motion sensor so that the door will automatically open. The door is equipped with pressure release latches which will allow the door to open to the full width once pressure, not exceeding 50 pounds, is	K 038	require one action to release. This will be accomplished by: A) The dining room and 200 hall exit discharge pathways were shoveled on 12/17/13 by maintenance staff. The facility will maintain an access control door at the facility entrance with a sensor and a manual release button with signage instructing "Push to Open". B) The maintenance staff will inspect exit discharge pathways for snow daily. The maintenance staff will monitor all exit doors quarterly for appropriate use of facility access control doors with sensors and manual release buttons with appropriate signage. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	

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K 038	Continued From page 4 applied to the door. At the time of the observation, the maintenance director reported he was unaware egress doors could not be locked where special knowledge is required to unlock the door and only one action is taken to release the door. On 12/17/13 at 10 AM, the executive director confirmed not every resident that had access to this door had a clinical need for the security of locking doors. Observation of the therapy entrance on 12/16/13 at 3:49 PM, showed the same aforementioned locking arrangement was placed on two consecutive sets of doors. In addition, these doors were provided with a 3 inch by 18 inch sticker on each door that read "In Emergency Push to Open". Reference NFPA 101, 2000 Edition; 19.2.1; 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. A.7.1.10.1 A proper means of egress allows unobstructed travel at all times. Any type of barrier including, but not limited to, the accumulations of snow and ice in those climates subject to such accumulations is an impediment to free movement in the means of egress. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more	K 038		

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K 038	Continued From page 5 than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Reference NFPA 101, 2000 Edition; 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
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	K052 The facility will ensure alarm system components are tested annually. This will be accomplished by: A) Fire alarm components were tested on 12/17/13. Batteries were tested and replaced on 1/13/14. B) The maintenance staff will inspect fire alarm testing records quarterly to ensure inspections are completed as scheduled..	2/1/14

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K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure 4 of 7 fire alarm system components were tested annually. The findings were: Review of the fire alarm system testing records showed the system was last tested on 11/19/13. Further review showed only 76 of 91 alarm notification devices were tested. Only 42 of 73 heat detectors were tested and there was no record of the last time the smoke dampers were tested. Review also showed the semi-annual fire alarm control panel battery load voltage test had not been performed six months previous to the 11/19/13 annual test. On 12/17/13 at 9:50 AM, the maintenance director could not explain why the fire alarm contractor had not performed a complete inspection of the fire alarm system components. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.7, 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 16. Initiating Devices a. Duct Detectors, ... annually b. Electromechanical Releasing Device (Smoke Dampers), ...annually e. Heat Detectors, ... annually f. Fire Alarm Boxes, ... annually	K 052	C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	

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K 052	Continued From page 7 19. Alarm Notification Appliances a. Audible Devices, ... annually c. Visible Devices, ... annually	K 052		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure combustible decorations were not used in 3 of 7 smoke compartments. The findings were: Observation of the corridor system on 12/16/13 between 1 PM and 5 PM, showed a live pine bough wreath was hung on the corridor door to resident room #407, #103 and #124. On 12/16/13 at 1:19 PM, the maintenance director reported he was aware live pine decorations are not allowed in healthcare facilities. He could not explain why the wreaths were hung. Reference NFPA 101, 2000 Edition; 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K073 The facility will ensure combustible decorations are not used. This will be accomplished by: A) Live pine bough wreaths were removed from resident room #407, #103, and #124 on 12/18/13. B) The maintenance staff will inspect facility for combustible decorations on a monthly basis. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	2/1/14
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 The facility will ensure that generator tests are performed. This will be accomplished by: A) Equipment used to inspect battery electrolyte levels was ordered on 1/9/14. Generator battery electrolyte levels will be inspected and logged on or before 2/1/14.	2/1/14

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K 144	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure 1 of 5 emergency generator tests was performed. The findings were: Review of the emergency generator testing log showed the facility was not inspecting the battery electrolyte levels on a weekly basis. On 12/17/13 at 9:50 AM, the maintenance director reported he was unaware of the aforementioned inspection. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.3, NFPA 110, 1999 Edition; 6.3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.	K 144	B) B) The maintenance staff will inspect and log generator battery electrolyte levels on a weekly basis. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.	K 211	K211 The facility will ensure alcohol based hand rub is properly stored. This will be accomplished by: A) The extra hand alcohol based hand rub was removed from laundry storage to ensure no more than 5 gallons of is present. B) The maintenance staff will randomly audit laundry storage to ensure no more	2/4/14

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K 211	Continued From page 9 o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure alcohol based hand rub was properly stored in 1 of 7 smoke compartments. The findings were: Observation of the laundry on 12/16/13 at 1:04 PM, showed there were 24 alcohol based hand rub containers stored on a storage shelf. Each container had a capacity of 1.2 liters, with a total combined volume 28.8 liters which is the 7.6 gallons. At the time of the observation, the maintenance director reported he was unaware a maximum quantity of 5 gallons of alcohol based hand rub could be stored in a single smoke compartment. Reference CFR 403.744, Survey and Certification Letter 05-33; 19.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.4.3 unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m). (2) The maximum individual dispenser fluid capacity shall be: (a) 0.3 gallons (1.2 liters, 1200 cc/ml, 40 oz.) for	K 211	than 5 gallons of alcohol based hand rub is present. C) Any findings will be reported at the facility Performance Improvement meeting for three months or until ongoing compliance is established.	

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K 211	Continued From page 10 dispensers in rooms, corridors, and areas open to corridors (b) 0.5 gallons (2.0 liters, 2000 cc/ml, 66.6 oz.) for dispensers in suites of rooms (3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) from each other. (4) Not more than an aggregate 10 gallons (37.8 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet. (5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (6) The dispensers shall not be installed over or directly adjacent to an ignition source. (7) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.	K 211		