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Healthcare Licensing and Surveys

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

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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	03/20/2014

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

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type V (000) construction built in 1961. The building was equipped with a supervised, automatic wet sprinkler system with anti-freeze loops and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 95.	K 000	**Preparation and/or execution of the response and plan of correction do not constitute admission of 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 the provisions of federal and state law require it.**	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	K-017 **Corrective Action** The ceiling tile in the therapy room having the 1-inch circular penetration has been replaced. The therapy room gaps in the escutcheon rings of the sprinkler heads have been sealed. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm ceilings do not have penetration openings and escutcheon rings are sealed against all sprinkler heads.	

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

Dan Stackis — Senior Administrator — 4-28-14

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 prog participation.

RESUBMITTED POC ACCEPTED ON 4/28/14 W/DAN STACKIS J. Wyatt

* Resubitted POC with changes per HLS. *

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K 017	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure ceilings were constructed to limit the transfer of smoke in 1 of 6 smoke compartments. The findings were: Observation of the ceiling in the Therapy Room on 03/20/14 at 11:00 AM showed the following openings in the ceiling : 1) 1-inch circular penetration in the ceiling above wall cabinets on the west side of this space, 2) Gaps at unsealed ceiling penetrations around the escutcheon rings of (2) sprinkler heads. At the time of the observation, the Maintenance Supervisor acknowledged that the ceiling openings and unsealed penetrations were present. REFERENCE NFPA 101, 2000 Edition 19.3.6.2 Construction of Corridor Walls. 19.3.6.2.1 Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke.	K 017	**Systemic Changes** The Maintenance Director/Designee will incorporate into the facility preventative maintenance program a monthly audit to confirm penetration openings do not exist on ceilings and/or escutcheon rings on sprinkler heads. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018		

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K 018	Continued From page 2 required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide corridor protection resisting the passage of smoke in 4 of 6 smoke compartments. The findings were: 1. Observation of the corridor door for Patient Room #130 on 03/20/14 at 10:15 AM showed the corridor latching mechanism required excessive force to insert into the strike plate. This was caused by rubber gasketing attached to the door frame. At the time of the observation, the Maintenance Supervisor acknowledged the excessive force required to engage the latch. 2. Observation of the corridor door for Patient Room #141 on 03/20/14 at 10:45 AM showed a	K 018	K-018 **Corrective Action** The strike plate for Room #130 will be adjusted to allow the door to latch to the door frame without excessive force. Room #141 and the Business Office's doors will have the ¼ inch hole above the door lever filled. The latch on the corridor doors in the dining room will be adjusted to close against the door frame. The center gasket on the dining room corridor doors will be replaced. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm doors latch to the door frame without excessive force, doors do not possess holes, and damaged door gaskets are replaced.	

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K 018	Continued From page 2 required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide corridor protection resisting the passage of smoke in 4 of 6 smoke compartments. The findings were: 1. Observation of the corridor door for Patient Room #130 on 03/20/14 at 10:15 AM showed the corridor latching mechanism required excessive force to insert into the strike plate. This was caused by rubber gasketing attached to the door frame. At the time of the observation, the Maintenance Supervisor acknowledged the excessive force required to engage the latch. 2. Observation of the corridor door for Patient Room #141 on 03/20/14 at 10:45 AM showed a	K 018	**Systemic Changes** The Maintenance Director/Designee will incorporate into the facility preventative maintenance program a monthly audit to confirm doors latch to the door frame without excessive force, doors do not possess holes, and damaged door gaskets are replaced. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. Requesting a time-limited extension until June 16, 2014. See attached letter.	

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K 018	Continued From page 3 1/4 " hole above the door ' s lever hardware. At the time of the observation, the Maintenance Supervisor acknowledged the hole in the door. 3. Observation of the corridor door for Business office adjacent to Patient Room #104 on 03/20/14 at 1:20 PM showed a 1/4 " hole above the door ' s lever hardware. At the time of the observation, the Maintenance Supervisor acknowledged the hole in the door. 4. Observation of the pair of corridor doors for dining area on 03/20/14 at 2:30 PM showed the doors would not latch and close completely into the door frame. In addition, the center gasket was damaged in several locations and would not provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Supervisor acknowledged the inability of the door to latch and the damaged gasket.	K 018		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 022	K-022 **Corrective Action** Exit signage and delayed egress signage near Room #133, #146, #115, and #105 will be replaced. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that exit and delayed egress signage are not faded and are legible.	

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K 022	Continued From page 4 facility failed to mark access to exits requiring delayed-egress in 4 of 6 smoke compartments. The findings were: Observation of (4) exit discharge locations (near Room #133, Room #146, Room #115 and Room #105) on 03/20/14 throughout the survey, showed the " EMERGENCY EXIT ONLY " and " PUSH UNTIL ALARM SOUNDS " and " DOOR CAN BE OPENED IN 15 SECONDS " signage was faded and was not legible. At the time of the observation, the Maintenance Supervisor acknowledged that the signage was faded and not legible. REFERENCE NFPA 101, 2000 Edition; 7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 022	**Systemic Changes** The Maintenance Director/Designee will incorporate into the facility preventative maintenance program a monthly audit to confirm that exit and delayed egress signage are not faded and are legible. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. K-027 **Corrective Action**	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	K 027	The cross-corridor smoke barrier doors near the dining room and Social Services office will have sweeps installed to reduce the gap between the bottom of the door and the floor leaving only the minimum clearance necessary. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all cross-corridor smoke barrier doors have a gap between the door and the floor leaving only the minimum clearance necessary.	

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K 027	Continued From page 5 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 6 cross-corridor smoke barriers doors were smoke resistant. The findings were: Observation of cross-corridor smoke barriers doors near the dining area and Social Service on 03/20/14 at 11:35 AM showed an undercut in excessive of 1-inch when both doors were fully closed. At the time of the observation, the Maintenance Supervisor acknowledged the excessive door undercut. REFERENCE NFPA 101, 2000 Edition; 8.3.4 Doors. 8.3.4.1 Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	**Systemic Changes** The Maintenance Director/Designee will incorporate into the facility preventative maintenance program a monthly audit to confirm that all cross-corridor smoke barrier doors have a gap between the door and the floor leaving only the minimum clearance necessary. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. Requesting a time-limited extension until June 16, 2014. See attached letter.	
K 038 SS=D	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 hardware	K 038	K-038 **Corrective Action** The hardware proximity sensor on the exit discharge door in the north lobby was adjusted and releases 15 seconds after the alarm sounds.	

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K 038	Continued From page 6 for an exit discharge was functional in 1 of 6 smoke compartments. The findings were: Observation of the exit discharge door in the north lobby on 03/20/14 at 10:40 AM showed the delayed-egress hardware did not release the door within the 15 seconds time period indicated on the door signage. At the time of the observation, the Maintenance Supervisor acknowledged that the delayed-egress mechanism did not function within the required timeframe. REFERENCE NFPA 101, 2000 Edition 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.	K 038	**Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all delayed egress on discharge doors release 15 seconds after the alarm sounds. **Systemic Changes** The Maintenance Director/Designee will comply with the facility's maintenance program by performing weekly tests on the delayed egress system for all discharge doors. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
K 052 S=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD Is not met as evidenced by: Based on documentation review and staff interview, the facility failed to ensure that fire alarm systems were tested and maintained. The	K 052		

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K 052	Continued From page 7 findings were: 1. Observation of service and testing logs provided by the facility on 03/20/14 at 10:15 AM indicated that correct operation of smoke dampers had not been verified by removal of the fusible links and operation of the dampers. In an interview conducted on 03/20/14 at 11:45 AM, the Maintenance Supervisor acknowledged that the fire dampers have not been tested and that no records exist. 2. Observation of service and testing logs provided by the facility on 3/20/14 at 10:30 AM indicated that smoke detectors had not been tested in place to ensure smoke entry into the sensing chamber and an alarm response by utilizing (1) of the (5) testing methods as indicated in NFPA 72. In an interview conducted on 03/20/14 at 11:45 AM, the Maintenance Supervisor stated that he believed this testing was being done by their contracted testing agency but that reports were not kept on-site. REFERENCES NFPA 72, 1999 Edition Table 7-2.2, Item 13.a.2 Electromechanically Releasing Device; Restorable Fusible Link: Correct operation shall be verified by removal of the fusible link and operation of the associated device. Any moving parts shall be lubricated as necessary. Table 7-2.2, Item 13.g.1 Smoke Detectors; System Detectors: The detectors shall be tested in place to ensure smoke entry into the sensing chamber and an alarm response. Testing with smoke or a listed aerosol approved by the manufacturer shall be permitted as acceptable	K 052	K-052 **Corrective Action** All ~~smoke~~ **fire** dampers will be inspected and serviced **and documentation will be maintained on-site.** Smoke detector testing to ensure smoke entry into the sensing chamber will be conducted **and documentation will be maintained on-site.** **Identification of Others** The Maintenance Director/Designee will confirm that appropriate documentation exists to support the testing of the ~~smoke~~ **fire** dampers and smoke detector testing **and documentation will be maintained on-site.** **Systemic Changes** The Maintenance Director/Designee will confirm that ~~smoke~~ **fire** dampers are inspected and serviced and smoke detectors are tested in accordance with the facility's maintenance program.	

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K 052	Continued From page 8 test methods. Other methods approved by the manufacturer that ensure smoke entry into the sensing chamber shall be permitted. Any of the following tests shall be performed to ensure that each smoke detector is within its listed and marked sensitivity range: (a) Calibrated test method; (b) Manufacturer ' s calibrated sensitivity test instrument; (c) Listed control equipment arranged for the purpose; (d) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit when its sensitivity is outside its listed range; (e) Other calibrated sensitivity test method approved by the authority having jurisdiction	K 052	**Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. Requesting a time-limited extension until June 16, 2014. See attached letter. K-056	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure there was adequate sprinkler coverage in 2 of 6 smoke compartments. The findings were:	K 056	**Corrective Action** The light in the alcove south area was removed **and the resulting illumination levels will be verified to meet the minimum requirements.** The light in the restorative dining room, which is an assisted dining area, was also removed **and the resulting illumination levels will be verified to meet the minimum requirements.** **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm that light fixtures do not impede the flow of water coming from sprinkler heads per **the requirements of NFPA 13.**	

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K 056	~~Continued From page 9~~ Observation of the Restoration Dining room and an alcove south of this location on 03/20/14 at 11:35 AM showed the sprinkler heads water discharge would be obstructed by hanging light fixtures. At the time of the observation, the Maintenance Supervisor acknowledged that the light fixture would obstruct the flow pattern of the sprinkler. REFERENCE NFPA 13, Installation of Sprinkler Systems, 1999 edition. 5-6.5.3* Obstructions that prevent Sprinkler Discharge from Reaching the Hazard. Continuous or non-continuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section.	K 056	**Systemic Changes** The Maintenance Director/Designee will confirm that any future light fixtures installed will not impede the flow of water coming from sprinkler heads **per the requirements of NFPA 13.** **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
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 that the required design information was posted on the fire sprinkler riser. The findings were: Observation of the fire riser on 03/20/14 at 3:06 PM showed that the fire riser had been modified	K 062	K-062 **Corrective Action** The signage articulating hydraulic design information will ~~be posted on the fire riser~~ **secure the services of a certified fire protection contractor to develop the required hydraulic calculations and submit any necessary modifications to the WDH for review in order to maintain a compliant automatic sprinkler system.**	

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CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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K 056	Continued From page 9 Observation of the Restoration Dining room and an alcove south of this location on 03/20/14 at 11:35 AM showed the sprinkler heads water discharge would be obstructed by hanging light fixtures. At the time of the observation, the Maintenance Supervisor acknowledged that the light fixture would obstruct the flow pattern of the sprinkler. REFERENCE NFPA 13, Installation of Sprinkler Systems, 1999 edition. 5-6.5.3* Obstructions that prevent Sprinkler Discharge from Reaching the Hazard. Continuous or non-continuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section.	K 056		
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 that the required design information was posted on the fire sprinkler riser. The findings were: Observation of the fire riser on 03/20/14 at 3:06 PM showed that the fire riser had been modified	K 062	**Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm if additional hydraulic design information signage is needed.	

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K 062	~~Continued From page 10~~ from the original installation for the addition of a reduce principle backflow preventer and valves. No hydraulic design information sign was provided. At the time of the observation, the Maintenance Supervisor indicated that he was unaware of the date of modification but that he would investigate providing the required information. REFERENCE NFPA 13 Installation of Sprinkler Systems 5-15.4.6.2 When backflow prevention devices are to be retroactively installed on existing systems, a thorough hydraulic analysis, including revised hydraulic calculations, new fire flow data, and all necessary system modifications to accommodate the additional friction loss, shall be completed as a part of the installation. 10-5 Hydraulic Design Information Sign. The installing contractor shall identify a hydraulically designed sprinkler system with a permanently marked weatherproof metal or rigid plastic sign secured with corrosion resistant wire, chain, or other approved means. Such signs shall be placed at the alarm valve, dry pipe valve, preaction valve, or deluge valve supplying the corresponding hydraulically designed area.	K 062	**Systemic Changes** The Maintenance Director/Designee will periodically inspect the condition of the sign placed on the fire riser **and ensure hydraulic calculations are updated to meet NFPA 13 whenever the automatic sprinkler system is modified.** **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. Requesting a time-limited extension until June 16, 2014. See attached letter.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K-067 **Corrective Action** The evaporative coolers will have smoke detectors and an automatic control installed in the supply air duct, if needed, based on the cubic feet per minute calculations provided by an outside consultant.	

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K 067	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide smoke detection and automatic control of roof-mounted evaporative coolers. The findings were: Observation of the roof-mounted evaporative coolers on 03/20/14 at 3:30 PM showed that smoke detectors and automatic control have not been provided in the supply air ductwork of each unit. It could not be established that the units supplied airflows of less than 2000 ft³/min. At the time of the observation, the Maintenance Supervisor acknowledged that the evaporative coolers did not have smoke detection and that operation was manual with no means of automatic control in the event of smoke infiltration. REFERENCES NFPA 90A 4-4.2 Smoke Detection for Automatic Control; Location, Smoke detectors listed for use in air distribution systems shall be located as follows. (1) Downstream of the air filters and ahead of any branch connections in air supply systems having a capacity greater than 2000 ft³/min.	K 067	**Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to determine if the evaporative coolers do not have smoke detectors and an automatic control installed in the supply air duct. An outside consultant will be used to determine the cubic feet per minute capacity for each evaporative cooler. **Systemic Changes** The Maintenance Director/Designee will conduct testing of the smoke detectors and automatic controls, if required, based on the outside consultant's findings. **Testing results, if required, will be maintained on-site.**	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all exhaust air shall pass through the grease filters in the commercial	K 069		

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K 067	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide smoke detection and automatic control of roof-mounted evaporative coolers. The findings were: Observation of the roof-mounted evaporative coolers on 03/20/14 at 3:30 PM showed that smoke detectors and automatic control have not been provided in the supply air ductwork of each unit. It could not be established that the units supplied airflows of less than 2000 ft³/min. At the time of the observation, the Maintenance Supervisor acknowledged that the evaporative coolers did not have smoke detection and that operation was manual with no means of automatic control in the event of smoke infiltration. REFERENCES NFPA 90A 4-4.2 Smoke Detection for Automatic Control; Location, Smoke detectors listed for use in air distribution systems shall be located as follows. (1) Downstream of the air filters and ahead of any branch connections in air supply systems having a capacity greater than 2000 ft³/min.	K 067	**Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014. Requesting a time-limited extension until June 16, 2014. See attached letter. K-069 **Corrective Action** The commercial hood friction fittings will be installed in the commercial cooking hood.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all exhaust air shall pass through the grease filters in the commercial	K 069	**Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to determine if any additional commercial hood friction fittings are required.	

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K 069	Continued From page 12 cooking hood. The findings were: Observation of the commercial cooking hood in the kitchen on 03/20/14 at 2:45 PM showed there were gaps in excessive of 3-inches on both grease filter assemblies. Operation of the hood showed movement of one of the filter panels in the direction of exhaust caused by the lack of an adequate friction fitting of the filter to the adjacent filters. At the time of the observation, the Maintenance Supervisor acknowledged that the required fittings were not in place and would investigate having them replaced. REFERENCES NFPA 101 Life Safety Code 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 96 6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air shall pass through the grease filters.	K 069	**Systemic Changes** The Maintenance Director/Designee will inspect on a monthly basis that the friction fittings and filter panels remain in-place. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 076		

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K 076	Continued From page 13 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 (1) to ensure that racks or fastenings are provided to protect O^2 cylinders from accidental damage or dislocation, (2) keep the storage location free of flammable and combustible materials, (3) to provide a dedicated enclosure with no other use, and constructed with a fire-resistive rating of at least 1-hour. The findings were: Observation of the O^2 storage room adjacent to Patient Room 116P on 03/20/14 at 2:03 PM showed that refrigerated liquid oxygen cylinders in excess of 8,800 cu. ft. are stored in what is an abandoned restroom. Several small oxygen cylinders were observed as being stored on the floor and in the abandoned bathtub without racks or fastenings. Additionally, (7) large 41 Liter containers were observed as being stored in the room without racks or fastening to protect against damage. Several instances of plastic bags and other combustible materials were noted in the room. At the time of the observation, the Maintenance Supervisor was not aware that the space utilization was out of compliance. REFERENCES NFPA 99	K 076	K-076 **Corrective Action** The oxygen room will have racks and/or fasteners provided for the storage of oxygen cylinders. Flammable materials will be removed from the oxygen room. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit other oxygen storage rooms to determine if racks and/or fasteners are available to store oxygen cylinders, the area is free of combustible materials, and address the dedicated enclosure part of the citation.	

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K 076	Continued From page 14 8-3.1.11.1 Storage for nonflammable gases greater than 3000 cu. ft. shall comply with 4-3.1.1.2 and 4-3.5.2.2. 4-3.1.1.2. (a).2 Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 4-3.1.1.2. (a).3 Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4-3.1.1.2. (a).5 Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials. 4-3.1.1.2. (a).7 Combustible materials such as paper, cardboard, plastics, and fabrics shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage.	K 076	**Systemic Changes** The Maintenance Director/Designee will incorporate into the monthly maintenance program the inspection of oxygen storage areas to confirm oxygen cylinders are placed in racks and/or fasteners, the area is free of combustible materials, and address the dedicated enclosure issue in the citation. **Monitoring** The Maintenance Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	