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

RECEIVED
WY Dept of Health
AUG 25 2014
Healthcare Licensing

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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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING	08/05/2014

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 102.	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	1. The corridor door to patient room #202 will be adjusted to ensure it latches properly. 2. The Maintenance Director will check 25% of the doors per month for four months during environmental rounds and correct any findings to ensure proper latching. 3. Audit results will be reported monthly though the facility PI/CQI program.	Correction Date 10/15/14 RS 9/17/14

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

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.

Modified POC Accepted via Phone Call with Carley Applegate on 9/17/14 @ 12:20pm
9/18/14

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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 provide corridor protection resisting the passage of smoke in 1 of 12 smoke compartments. The findings were: 1. Observation of the corridor door for Patient Room #202 on 08/05/14 at 12:15 PM showed the door would close completely into the door frame, but would not latch and provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to latch.	K 018		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	1. Identified stairwell doors will be repaired and adjusted to ensure they latch properly. 2. The oxygen storage room door adjacent to room #115 will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke. 3. The soiled utility room door adjacent to room #115 will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke.	Correction Date 10/5/14 gas 9/17/14

8/25/14

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	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEALTH CARE B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 021	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide protection of vertical openings from the passage of fire and smoke in 1 of 4 stairwells and protection of hazardous area enclosures in 3 of 12 smoke compartments The findings were: 1. revealed that the doors at both ends of the stairwell would not close completely into the the Maintenance Manager acknowledged the inability of the doors to fully close and latch. 2. Observation of the corridor door for the Oxygen Storage Room adjacent to Room #116 on 08/05/14 at 2:41 PM showed the door would not close completely into the door frame and latch to provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to fully close and latch. 3. Observation of the corridor door for the Soiled Utility Room adjacent to Room #115 on 08/05/14 at 2:43 PM showed the door would not close completely into the door frame and latch to provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to fully close and latch. 4. Observation of the corridor doors for the Laundry Room on 08/5/14 at 3:39 PM showed a manual bolt on both the active and inactive leafs. The Maintenance Manager acknowledged that the manual bolt on the inactive leaf did not provide a positive latch keeping the doors secured into the frame.	K 021	4. A proper latch will be installed for the laundry room door and the manual bolt will be removed. The door will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke. 5. The supply room door adjacent to the laundry room will be repaired or adjusted to ensure proper latching and prevention of the passage of smoke. 6. The corridor supply room door adjacent to the employee break room will be repaired or adjusted to ensure proper latching and the prevention of the passage of smoke. 7. The corridor door the housekeeping bathroom/storage room adjacent to the supply room will be repaired or adjusted to ensure proper latching and the prevention of the passage of smoke. 8. The Maintenance Director will check 25% of the doors per month for four months during environmental rounds and correct any findings to ensure proper latching.	Correction DATE OF ALL TAGS THIS PAGE. 10/5/14 9/17/14 RS

8/25/14

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K 021	Continued From page 3 5. Observation of the corridor door for the Supply Room adjacent to Laundry on 08/05/14 at 3:52 PM showed the door would not close completely into the door frame and latch to provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to fully close and latch. 6. Observation of the corridor door for the Storage Room adjacent to the Employee Breakroom on 08/05/14 at 3:57 PM showed the door would not close completely into the door frame and latch to provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to fully close and latch. 7. Observation of the corridor door for the Housekeeping Bathroom/Storage Room adjacent to the Supply Room on 08/05/14 at 4:11 PM showed the door would not close completely into the door frame and latch to provide a resistance to the passage of smoke. At the time of the observation, the Maintenance Manager acknowledged the inability of the door to fully close and latch.	K 021		
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	K 027	1. The secured unit corridor doors will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke. 2. The corridor doors adjacent to room #111 will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke.	Correction Dates 10/5/14 9/11/14

8/28/14

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K 027	Continued From page 4 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide protection of smoke barriers in 2 of 12 smoke compartments. The findings were: 1. Observation of the cross corridor doors for the Secured Unit on 08/05/14 at 11:53 AM showed the doors would not close completely into the door frame and would not provide a resistance to the passage of smoke. The Maintenance Manager at the time of the observation acknowledged the inability of the door to close completely into the frame. 2. Observation of the cross corridor doors adjacent to Room #111 on 08/05/14 at 2:23 PM showed the doors would not close completely into the door frame and would not provide a resistance to the passage of smoke. The Maintenance Manager at the time of the observation acknowledged the inability of the doors to close completely into the frame. 3. Observation of the cross corridor doors adjacent to Room #116 on 08/05/14 at 2:38 PM showed the doors would not close completely into the door frame and would not provide a resistance to the passage of smoke. The Maintenance Manager at the time of the observation acknowledged the inability of the doors to close completely into the frame.	K 027	3. The corridor doors adjacent to room #116 will be repaired or adjusted to ensure proper latching and resistance to the passage of smoke. 4. The Maintenance Director will check 25% of the doors per month for four months during environmental rounds and correct any findings to ensure proper latching. 5. Audit results will be reported monthly though the facility PI/CQI program.	Correction Date 10/5/14 gs 9/17/14
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

8/25/14

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K 038	Continued From page 5 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 that exit access is arranged and readily accessible at all times in 2 of 12 smoke compartments. The findings were: 1. Observation of stairwell door behind the elevators on the 3rd floor on 8/05/14 at 12:00 PM revealed the door was controlled access with a key pad and was provided with signage indicating " Exit " . Interview with the Facility Maintenance Manager at the time of the observation confirmed that the door was not a required means of egress due to additional stairs at the end of each wing. 2. Observation of the exit discharge door in the Business Office hallway on 08/05/14 at 2:68 PM showed the delayed-egress hardware required more than 15lbs to acuate the door and release within the 15 seconds time period indicated in NFPA 101. At the time of the observation, the Maintenance Manager acknowledged that the delayed-egress mechanism did not function as required. REFERENCE NFPA 101, 2000 Edition 7.2.1.6.1	K 038	1. The exit sign over the stairwell door behind the elevators on the 3rd floor will be removed. 2. The delayed egress hardware on the exit door in the business office hallway will be repaired or replaced to ensure that it functions correctly per NFPA 101. 3. The Maintenance Director will check 25% of the facility doors which have delayed egress hardware during environmental rounds for four months and correct any findings to ensure proper latching. 4. Audit results will be reported monthly though the facility PI/CQI program.	Correction Date 10/5/14 RS 9/17/14
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		

8/26/14

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K 046	Continued From page 6 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 document review & staff interview, the facility failed to provide documentation of monthly and annual emergency lighting tests. The findings were: Document review on 08/05/14 from 10:20 AM until 11:45 AM revealed that no record of any emergency lighting tests had been completed in the last twelve months. (NFPA 101 7.9.3) Interview with the Facility Administrator at the time of the document review verified that no documentation was available.	K 046	1. A monthly lighting test will be completed by the Maintenance Director beginning Sept 2014 and occurring each month forward. Identified repairs will be completed within 2 weeks of the emergency test and test results will be provided to the Executive Director monthly. 2. Emergency lighting test results will be provided to the PI/CQI committee monthly.	Correction Date 10/5/14 gs 9/17/14
K 050 SS=E	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 announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of fire drill records and staff interview, the facility failed to ensure fire drills were held on a quarterly basis for all shifts. The findings were:	K 050	1. Quarterly fire drills will be initiated beginning September 2014 and will continue with one per shift per quarter going forward. Fire drill results will be documented and provided to the Executive Director each month. 2. Identified deficient practices will be submitted to the PI/CQI committee to include appropriate action plans.	Correction Date 10/5/14 gs 9/17/14

8/28/14

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K 050	Continued From page 7 Review of the fire drill records on 8/05/14 from 10:20 AM to 11:45 AM showed the first shift occurred between 6 AM - 2 PM, the second shift occurred between 2 PM - 10 PM, and the third shift occurred between 10 PM - 6 AM. Further review showed all documentation of fire drills for the month of April 2014 were missing. At the time of the review, the Facility Administrator acknowledged the lack of documentation for the month of April. It was noted that the prior Maintenance Manager had removed documentation at the termination of his employment.	K 050		
K 052 SS=E	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 review of fire alarm testing and maintenance records and staff interview, the facility failed to provide documentation identifying required fire alarm tests. The findings were: Review of the fire alarm testing and maintenance	K 052	1. The fire alarm activation will be conducted in September 2014 and monthly thereafter. The semiannual battery load test will be completed September 2014 and then semi-annually thereafter. 2. Results will be provided to the Executive Director and any deficient practice will be taken through the facility PI/CQI committee to include appropriate action plans.	Correction Date 10/5/14 9/5 9/10/14

8/28/14

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K 052	Continued From page 8 records on 8/05/14 from 10:20 AM to 11:45 AM showed the monthly fire alarm activation as required by NFPA 72 (Table 7-3.2, 14) and the semi-annual battery load voltage test as required by NFPA 72 (Table 7-3.2 6, c, 3) were both not documented. At the time of the review, the Facility Administrator acknowledged the lack of documentation. It was noted that the prior Maintenance Manager had removed documentation at the termination of his employment	K 052		
K 067 SS=D	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 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to ensure that HVAC systems are tested per the requirements of NFPA 90A. The findings were: Document review and staff interview on 8/5/14 between 10:20 AM and 11:45 AM revealed that no documentation was available to indicate that fire dampers are being tested on a 4-year basis in accordance with NFPA 90A, Section 3-4.7. Interview with the Facility Administrator at the time of document review acknowledged that testing was not being performed.	K 067	1. Fire dampers will be tested and documented by 9/15/14. Any identified repairs will be corrected by the Maintenance Department or designee. 2. Damper testing and repairs will be documented and provided to the Executive Director and PI/CQI committee. 3. The facility will establish a system to track all HVAC and damper equipment for proper testing and preventative maintenance in accordance with NFPA standards.	Correction Date 10/15/14 9/17/14
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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K 144	Continued From page 9 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on document review and staff interview on 08/05/14 from 10:20 AM to 11:45 AM revealed, the facility failed to ensure monthly load tests, and weekly maintenance inspections were being performed for the generator. The findings were: 1. The generator test for the months of June and July 2014 were missing. Per NFPA 99-1999, Section 3-4.4.1.1, Generator sets shall be tested twelve times a year with testing intervals not less than 20 days or exceeding 40 days. 2. The records for the generator did not ascertain performing the weekly inspections. There were no detailed checklists of the inspection as recommended by NFPA 110 provided with the records for the months of June and July 2014. Interview with the Facility Administrator during the document review confirmed that the documentation for the monthly generator tests, and weekly maintenance inspections were missing.	K 144	1. The Maintenance Director or designee will complete a generator test under load by 9/15/14 and each month thereafter. 2. Weekly inspections will be completed beginning 9/15 and documented. Any identified repairs will be corrected within two weeks of the test and reported to the Executive Director. 3. Generator testing and repairs will be reported to the PI/CQI committee quarterly.	Correction Date 10/5/14 9/1/2008

8/25/14