| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535032 | A. BUILDING _____ B. WING _____ | 01/06/2015 |

| 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 |
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| K 000 | INITIAL COMMENTS<br><br>Requirements for Long Term Care Facilities<br>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.<br><br>The facility was a fully sprinklered, single story building of Type V (111) construction separated by five, 2 hour rated fire barriers 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 123 residents. | K 000 | | |
| K 018<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>Roller latches are prohibited by CMS regulations in all health care facilities. | K 018 | K018 The facility will ensure that corridor doors have no impediments to the closing of doors. This will be accomplished by:<br><br>A) Doors to Therapy East Clean Linen Room, Therapy West Spa, North Hall Clean Linen Room, and North Hall Charting Room have had door strike adjusted on 01/28/15.<br><br>B) The maintenance staff will randomly observe corridor room doors on a quarterly basis. If a door fails to close securely with appropriate amount of force maintenance will immediately adjust the door and/or | 02/20/15 |

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

Executive Director 2/2/15

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 Approved via Phone Call with Bryan Merrell Administrator on 2/10/15 @ 9:50 AM 34554

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| K 018 | Continued From page 1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide corridor protection resisting the passage of smoke in 4 of 7 smoke compartments. The findings were:<br><br>1. Observation of the corridor door for the Therapy East Clean Linen Room on 01/05/15 at 10.52 AM showed the door latching mechanism required excessive force to insert into the strike plate. At the time of the observation, the Facility Maintenance Manager acknowledged the excessive force required to engage the latch.<br><br>2. Observation of the corridor door for the Therapy West Spa on 01/05/15 at 12:04 PM showed the door latching mechanism required excessive force to insert into the strike plate. At the time of the observation, the Facility Maintenance Manager acknowledged the excessive force required to engage the latch.<br><br>3. Observation of the North Hall Clean Linen Room door on 01/05/15 at 12:17 PM showed the door latching mechanism required excessive force to insert into the strike plate. At the time of the observation, the Facility Maintenance Manager acknowledged the excessive force required to engage the latch.<br><br>4. Observation of the 400 North Hall Charting Room door on 01/05/15 at 12:21 PM showed the door latching mechanism required excessive force to insert into the strike plate. At the time of the observation, the Facility Maintenance | K 018 | latch to ensure to door closes securely.<br><br>C) Maintenance staff will report quarterly at the Performance Improvement meeting the findings of their observations. This will happen for one quarter or until ongoing compliance is achieved. | |

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| K 018 | Continued From page 2<br>Manager acknowledged the excessive force required to engage the latch.<br><br>Ref: 2000 NFPA 101, Section 19.3.6.3.2 | K 018 | | |
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 3 of 7 smoke compartments. The findings were:<br><br>1. Observation of the Main Electrical Room on 01/05/15 at 10:32 AM revealed the area was utilized for storage of combustible supplies, and equipment. A self-closing device was not provided for the door. At the time of the observation, the Facility Maintenance Manager acknowledged the door was not provided with a self-closing device.<br><br>2. Observation of the Physical Therapy Storage | K 029 | K029 One hour fire rated construction or an approved automatic fire extinguishing system protects hazardous areas. Doors are self-closing.<br><br>A) All combustible material was removed from and a door closer was installed in the Main Electrical Room on 01/28/15. A door closer was installed on the Therapy Storage Room on 01/27/15. A door closer was installed on the Construction Office door on 01/30/15.<br><br>B) The maintenance staff will randomly observe rooms with combustibles to ensure the door is equipped with a self-closing device on a quarterly basis. If a door is determined to need a self-closing device, maintenance will immediately install the self-closing device and ensure it operates properly.<br><br>C) Maintenance staff will report quarterly at the Performance | 02/20/15 |

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

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| K 029 | Continued From page 3<br>Room on 01/05/15 at 11:25 AM revealed the room was utilized for the storage of combustible supplies and equipment. A self-closing device was not provided for the door. At the time of the observation, the Facility Maintenance Manager acknowledged the door was not provided with a self-closing device.<br><br>3. Observation of the Construction Office on 01/05/15 at 2:44 PM revealed the room was utilized for the storage of combustible supplies, and equipment. A self closing device was not provided for the door. At the time of the observation the Facility Maintenance Manager acknowledged the door was not provided with a self closing device.<br><br>Ref: 2000 NFPA 101, Section 19.3.2.1 | K 029 | Improvement meeting the findings of their observations. This will happen for one quarter or until ongoing compliance is achieved. | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure exits are readily accessible at all times. The findings were:<br><br>1. Observation of the exit discharge door in the Dining Room on 01/05/15 at 2:25 PM showed the delayed-egress hardware did not release the door within the 15 seconds time period. At the time of the observation, the Facility Maintenance | K 038 | K038 Exit access is arranged so that exits are readily accessible at all times.<br><br>A) The dining room Exit Discharge door had the magnetic holder adjusted so door opens within 15 seconds adjusted on 01/30/15 by maintenance. Therapy West and South Hall exit doors were cleared from snow and ice on 01/05/15.<br><br>B) The maintenance staff will randomly observe delayed-egress hardware on exit doors to ensure proper function on a quarterly basis. If delayed-egress hardware does not function | 02/20/15 |

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| K 038 | Continued From page 4<br>Manager acknowledged the the delayed-egress mechanism did not function within the required time frame.<br><br>Ref: 2000 NFPA 101, Sections 19.2.1 and 7.2.1.6.1<br><br>2. Observation of the Therapy West Exit and the South 200 Hall Exit on 01/05/15 at 12:06 PM and 12:36 PM revealed snow and ice on both sidewalks impeding the means of egress. At the time of the observation, the Facility Maintenance Manager acknowledged the snow and ice on the walkways.<br><br>Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1.9 | K 038 | properly maintenance will immediately repair the delayed-egress hardware and ensure it functions properly. Maintenance staff will observe egress doors sidewalks to ensure they are free from snow and ice daily and maintenance will immediately clear any snow or ice identified from egress door sidewalks.<br><br>C) Maintenance staff will report quarterly at the Performance Improvement meeting the findings of their observations. This will happen for one quarter or until ongoing compliance is achieved. | |
| K 076<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to store liquid oxygen cylinders in accordance with NFPA 99. The findings were: | K 076 | K076 Medical gas storage and administration areas are protected<br>A) All combustible material in the Oxygen Storage Transfill Room were removed on 01/05/15. A sign was posted in Oxygen Storage Transfill room door on 01/06/15 reminding staff to keep room clear of combustible material.<br><br>B) The maintenance staff will randomly observe Oxygen Storage Transfill Room weekly to ensure it is clear of any combustible material. If combustible material is found maintenance will immediately remove it from the room. | 02/20/15 |

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| K 076 | Continued From page 5<br><br>Observation of the Oxygen Storage Transfill Room on 01/05/15 at 10:26 AM revealed combustible materials were being stored within the room. Multiple plastic bags, paper aprons, and plastic bottles were found stored on a metal wired shelf. At the time of the observation, the Facility Maintenance Manager acknowledged the combustible materials in the room and had them immediately removed.<br><br>Ref: 2000 NFPA 101, Section 19.3.2.4<br>Ref: 1999 NFPA 99, Section 4-3.1.1.2 (7) | K 076 | C) Maintenance staff will report quarterly at the Performance Improvement meeting the findings of their observations. This will happen for one quarter or until ongoing compliance is achieved. | |