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

PRINTED: 06/26/2015
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	06/15/2015

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 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 99.	K 000	**Cheyenne Health Care Center- Life Safety Survey – 6/15/2015 – Plan of Corrections** Preparation and/or execution of this plan of correction does not constitute admission or 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 it is required by the provisions of federal and state law. This plan of correction serves as the facility's allegation of compliance.	
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 – Corridor Doors **Corrective Action** The facility maintenance director has adjusted the door closer so that the door properly shuts and latches as required per the LS code. **ID of Others** The facility Maintenance Director will review all doors in the home with a closer that opens to a corridor to ensure that the each door and mechanism function properly. This audit will be completed before the date of compliance and will correct issues upon discovery. **Systemic Change** The facility Maintenance Director (M Dir) will be educated by the facility NHA/Designee in regard to the requirements of the life safety code	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Administrator — (X6) DATE 7/10/15

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.

JUL 10 2015

POC Accepted VIA Phone Call with The Administrator John Stewart on 7-14-15 at 1:46pm
34354

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

PRINTED: 06/26/2016
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	06/15/2015

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 018	Continued From page 1	K 018	pertaining to door closures. The education will occur prior to the date of compliance. **Monitoring** The M Dir will audit each door in the facility that opens to a corridor and contains a closer. The audits will occur monthly for 3 months to ensure that changes are sustained. The Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
K 029 SS=D	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors to the corridor that resist the passage of smoke in 1 of 6 smoke compartments. The findings were: Observation on 06/15/15 at 10:51 AM revealed the corridor door to the physical therapy department was provided with a self-closing device, but when activated would not fully close the door into the frame to resist the passage of smoke. At the time of the observation the facility maintenance manager acknowledged the door would not fully close. 2000 NFPA 101, Sections 19.3.6.3.1 and 19.3.6.3.2 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	K 029	K 029 – Fire Ratings **Corrective Action** The door leading to the kitchen now closes properly. The storage room in the Dining Room now closes properly after an adjustment by the M Dir. **ID of Others** The M Dir will conduct an audit of all storage areas to ensure the closer works properly, the review will occur before the date of compliance. Additionally, the M Dir will conduct an audit of all doors equipped with	

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

PRINTED: 06/26/2015
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 _____	06/15/2015

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 029	Continued From page 2 facility failed to provided smoke resistive doors to hazardous areas in 1 of 6 smoke compartments. The findings were: 1. Observation on 06/15/15 at 2:36 PM revealed the door leading to the kitchen was provided with a self-closing device, but when activated would not fully close the door into the frame. At the time of the observation the facility maintenance manager acknowledged the door would not fully close. 2. Observation on 06/15/15 at 2:50 PM revealed the storage room in the dining room area was larger than 50 square feet. The door to the storage area was provided with a self-closing device, but when activated would not fully close the door into the frame. At the time of the observation the facility maintenance manager acknowledged the door would not fully close.	K 029	closers to ensure they function properly. **Systemic Change** Education will be provided by the NHA/Designee to the M Dir in regard to the proper life safety requirements for storage areas and door closers. The education will occur before the date of compliance. **Monitoring** The M Dir will conduct monthly audits of the facility storage areas to ensure the doors close properly. Additionally, the M Dir will conduct a monthly audit of all door closers in the home to ensure they remain in proper function. Both audits will be done monthly for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
K 038 SS=D	2000 NFPA 101, Sections 19.3.2.1 and 3.3.13.2 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 continuously maintain a means of egress free of obstructions or impediments to full instant use in case of fire or emergency in 2 of 6 smoke compartments. The findings were:	K 038	K 038 – Exit/Egress **Corrective Action** The door that exits the Laundry area was adjusted by the M Dir to ensure	

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

PRINTED: 06/26/2015
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 _____	06/15/2015

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 038	Continued From page 3 1. Observation on 06/15/15 at 11:47 AM revealed the laundry room exit door required more than 30lbf to set the door in motion due to mis-alignment. At the time of the observation the facility maintenance manager acknowledged the excess force needed to set the door in motion. 2. Observation on 06/15/15 at 1:44 PM revealed the north lobby delayed egress door did not function or alarm when the panic hardware was activated. At the time of the observation the facility maintenance manager acknowledged the delayed egress hardware did not function. The magnetic lock was manually disengaged at that time, and will be left unlocked until the door can be repaired. Ref: 2000 NFPA 101, Sections 19.2.2.2.1, 7.2.1.4.5, and 7.2.1.6.1	K 038	proper function and that the door could be more easily opened. The North Lobby door was repaired and now functions properly. **ID of Others** The M Dir will conduct an audit of all external doors to ensure the doors are functioning properly in regard to delayed egress. The doors will also be inspected to see that they open without an excessive amount of force. **Systemic Change** The M Dir will receive education in regard to the Life Safety code pertaining to the proper closing and opening of doors. The education will be conducted by the NHA/Designee and will occur before the date of compliance. **Monitoring** The facility M Dir will conduct a monthly audit of all external doors to ensure that the doors continue to open and close properly. These audits will occur monthly for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 observation, document review, and staff interview the facility failed to demonstrate an approved maintenance and testing program for emergency lighting. The findings were: 1. Observation on 06/15/15 at 11:31 AM revealed the emergency lighting located in the boiler room would not function. When the test button was activated the lighting would not turn on. At the	K 046		

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

PRINTED: 06/26/2015
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 _____	06/15/2015

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 046	Continued From page 4 time of the observation the facility maintenance manager acknowledged the lighting did not function, but stated it had been checked about 2 weeks ago and was functioning. 2. Document review on 06/15/15 at 3:20 PM revealed no maintenance documentation was available for the monthly or annual emergency lighting tests. At the time of the review the facility maintenance manager acknowledged the documentation was not available, but stated he had been doing the checks and not documenting the results. Ref: 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3	K 046	reassess the need for continued monitoring based on compliance. Date 7/23/15 K 046 – Emergency Lighting **Corrective Action** A new light was ordered and installed to replace the non-functioning light in the boiler room. The facility has conducted a testing of all emergency lighting. **ID of Others** The M Dir will conduct an audit of all emergency lighting to inspect for proper function. The audit will occur before the date of compliance. **Systemic Change** The M Dir will be educated by the NHA/Designee in regard to the Life Safety code and the requirements of conducting emergency lighting tests on a monthly and annual basis. The education will occur before the date of compliance. **Monitoring** The monitoring will follow the corrective action in that the emergency lighting will need to be tested monthly and the results of the audits will be presented at the QAPI meeting for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on	
K 062 SS=D	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 ensure that automatic sprinkler systems are continuously maintained per the requirements of NFPA 25. The findings were: Observation on 06/15/15 at 10:45 AM revealed the sprinkler head located in the physical therapy closet was obstructed by boxes that were stacked on the top shelf approximately 6 inches away from the head. At the time of the observation the facility maintenance manager acknowledged that	K 062		

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

PRINTED: 06/26/2015
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	06/15/2015

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 062	Continued From page 5 the required 18 inch spacing from the bottom of the sprinkler head had not been maintained. Ref: 2000 NFPA 101, Section 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 5-6.5.3	K 062	trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide ashtrays in accordance	K 066	K 062 – Sprinkler Systems **Corrective Action** The obstruction in the Therapy Closet was removed by the M Dir and allows the head to function properly. **ID of Others** The M Dir will conduct an audit before the date of compliance for all closets in the home to ensure that the sprinkler coverage is not obstructed. **Systemic Change** The Rehab team members who are in charge of the space will receive education in regard to the Life Safety code from the NHA/Designee as to what is acceptable in the storage area for the sprinklers to function properly. The education will occur before the date of compliance. **Monitoring** The M Dir will conduct an audit of all public use closets to ensure that closet areas are not obstructed in regard to sprinkler coverage. This audit will occur monthly for 3 months. Results will be reported to the Quality	

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

PRINTED: 06/26/2015
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	06/15/2015

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 066	Continued From page 6 with the requirements of the Life Safety Code. The findings were: 1. Observation on 06/15/15 at 11:11 AM revealed the court yard adjacent to the maintenance shop was provided with two plastic buckets being utilized as ash trays. In addition the garbage can located in the court yard had evidence of being used to extinguish cigarettes on the lid. Further observation revealed cigarette butts and empty packaging located inside the garbage can. At the time of the observation the facility maintenance manager acknowledged the combustible ashtrays. 2. Observation on 06/15/15 at 11:20 AM revealed the exterior building being utilized as the maintenance shop had cigarette butts located on the carpeted floor. Further observation revealed cigarette butts and empty packaging located inside the garbage can located in the maintenance shop. At the time of the observation the facility maintenance manager acknowledged the cigarette butts on the floor and in the garbage can inside the building. 3. Observation of 06/15/15 at 2:05 PM revealed the kitchen patio entrance was utilized as a smoking area. A plastic bucket was provided for an ashtray. Further observation revealed a large amount of cigarette butts located on the ground throughout the patio area. At the time of the observation the facility maintenance manager acknowledged the combustible ashtray and cigarette butts on the ground. 4. Observation on 06/15/15 at 2:45 PM revealed the resident smoking area was provided with a wood barrel as an ashtray. Upon observation it	K 066	Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15 K 066 – Smoking regulations **Corrective Action** The combustible ashtrays were removed. The cigarette butts were removed from the Maintenance Shed. The plastic bucket was removed from the smoking area and will be replaced with proper ashtrays for the area. The wooden barrel was removed from the area during the survey. **ID of Others** The M Dir will conduct an audit of the current resident smoking area as well as the current staff smoking area (next to the Maintenance Shed) to ensure all ashtrays meet Life Safety requirements. The audit will occur before the date of compliance. **Systemic Change** Education will be provided to the M Dir in regard to the LS code surrounding acceptable items for use in a smoking area. The education will	

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

PRINTED: 06/26/2015
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 _____	06/15/2015

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 066	Continued From page 7 was noted that the wooden barrel was full of cigarette butts and empty packaging. At the time of the observation the facility maintenance manager acknowledged the use of the wooden barrel as an ashtray. Ref: 2000 NFPA 101, Section 19.7.4	K 066	be provided by the NHA/Designee and occur before the date of compliance. **Monitoring** The NHA/designee will conduct a monthly audit of the resident smoking area and the staff smoking area to ensure that the areas remain free from unacceptable items per the LS code. The audits will occur for 3 months to ensure the sustained changes. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
K 106 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide control functions for emergency and stand by power systems per the requirements of NFPA 110. The findings were: Observation on 06/15/15 at 11:22 AM revealed that the generator emergency stop button was located at the south nurses station, but was not provided with a cover to prevent accidental activation. At the time of the observation the stop button had been inadvertently activated by staff while sitting on the ledge directly below the button. At the time of the observation the facility maintenance manager acknowledged the emergency stop button had no protection from being inadvertently activated by staff.	K 106	K 106 - Generator **Corrective Action** A proper switch cover was ordered for the Generator button and will be installed upon arrival. **ID of Others** The M Dir will inspect all Generator switches in the home to ensure they meet the proper requirements. The review will occur before the date of compliance. **Systemic Change**	

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

PRINTED: 06/26/2015
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	06/15/2015

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 106	Continued From page 8 Ref: 1999 NFPA 110, Section 3-5.5.6	K 106	The M Dir will receive education in regard to the requirements for a generator by the NHA/Designee before the date of compliance. **Monitoring** The M Dir will conduct a monthly audit for 3 months to confirm that the changes made have been sustained and that the switches still work properly. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff were trained in the use and operation of small portable liquid oxygen systems per the requirements of CGA Pamphlet p-2.7 (Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems) The findings were: Observation on 06/15/15 at 11:00 AM of the south west corridor oxygen room revealed transfilling of	K 143	K 143 – Oxygen Transfer **Corrective Action** A CGA pamphlet will be emailed by the Life Safety surveyor so that the home can place them in the oxygen transfer room. **ID of Others** The M Dir will audit all Oxygen transfer rooms to ensure that each room has PPE and a CGA pamphlet. **Systemic Change** Education will be provided to facility staff in regard to the requirements and use of PPE during an oxygen transfer.	

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

PRINTED: 06/26/2015
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 _____	06/15/2015

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 143	Continued From page 9 liquid oxygen was occurring in the room. Safety equipment was located in the room for use, but a CGA Pamphlet was not. A nursing assistant was observed leaving the room, and when interviewed was unaware of the safety equipment and its use during filling. Further interview with the facility maintenance director revealed that education was not provided to staff on the proper care, use, and filling of liquid portable systems. Ref: 2000 NFPA 101, Sections 19.3.2.4 1999 NFPA 99, Section 8-6.2.5.2 2000 CGA P-2.7	K 143	The education will be provided before the date of compliance by the NHA/Designee. **Monitoring** The M Dir will conduct an audit of Oxygen transfer rooms to ensure that the CGA pamphlet remains and that the PPE is in the room. The audits will be monthly for a period of 3 months to sustain the changes. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	
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. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation on weekly inspections, and monthly load tests on the generator in compliance with the requirements of NFPA 110. The findings were: Document review and interview on 06/15/15 at 3:15 PM revealed the absence of documentation on the weekly inspections, and monthly load tests	K 144	K 144 – Generator Inspection **Corrective Action** The facility has conducted a test of the generator. **ID of Others** The M Dir will conduct an audit of all generators in the facility to ensure that each is tested on the proper cycle. The audit will occur before the date of compliance. **Systemic Change** The M Dir will receive education before the date of compliance in	

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

PRINTED: 06/26/2015
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	06/15/2015

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 144	Continued From page 10 for the generator. Interview with the Facility Maintenance Manager at the time of the review acknowledged the lack of documentation and testing of the generator. Ref: 1999 NFPA 99, Section 3-4.4.1.1 1999 NFPA 110, Sections 6-4.1 and 6-4.2	K 144	regard to the proper need for generator testing per the LS code. The education will be provided by the NHA/Designee. **Monitoring** The M Dir will continue to test the generator monthly as required and bring the reviews each month to QAPI for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date 7/23/15	

Cheyenne Health Care Center- Life Safety Survey – 6/15/2015 – Plan of Corrections

Preparation and/or execution of this plan of correction does not constitute admission or 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 it is required by the provisions of federal and state law.

This plan of correction serves as the facility's allegation of compliance.

K 018 – Corridor Doors

Corrective Action

The facility maintenance director has adjusted the door closer so that the door properly shuts and latches as required per the LS code.

ID of Others

The facility Maintenance Director will review all doors in the home with a closer that opens to a corridor to ensure that the each door and mechanism function properly. This audit will be completed before the date of compliance and will correct issues upon discovery.

Systemic Change

The facility Maintenance Director (M Dir) will be educated by the facility NHA/Designee in regard to the requirements of the life safety code pertaining to door closures. The education will occur prior to the date of compliance.

Monitoring

The M Dir will audit each door in the facility that opens to a corridor and contains a closer. The audits will occur monthly for 3 months to ensure that changes are sustained. The Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 029 – Fire Ratings

Corrective Action

The door leading to the kitchen now closes properly.

The storage room in the Dining Room now closes properly after an adjustment by the M Dir.

ID of Others

The M Dir will conduct an audit of all storage areas to ensure the closer works properly, the review will occur before the date of compliance. Additionally, the M Dir will conduct an audit of all doors equipped with closers to ensure they function properly.

Systemic Change

Education will be provided by the NHA/Designee to the M Dir in regard to the proper life safety requirements for storage areas and door closers. The education will occur before the date of compliance.

Monitoring

The M Dir will conduct monthly audits of the facility storage areas to ensure the doors close properly. Additionally, the M Dir will conduct a monthly audit of all door closers in the home to ensure they remain in proper function. Both audits will be done monthly for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 038 – Exit/Egress

Corrective Action

The door that exits the Laundry area was adjusted by the M Dir to ensure proper function and that the door could be more easily opened.

The North Lobby door was repaired and now functions properly.

ID of Others

The M Dir will conduct an audit of all external doors to ensure the doors are functioning properly in regard to delayed egress. The doors will also be inspected to see that they open without an excessive amount of force.

Systemic Change

The M Dir will receive education in regard to the Life Safety code pertaining to the proper closing and opening of doors. The education will be conducted by the NHA/Designee and will occur before the date of compliance.

Monitoring

The facility M Dir will conduct a monthly audit of all external doors to ensure that the doors continue to open and close properly. These audits will occur monthly for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 046 – Emergency Lighting

Corrective Action

A new light was ordered and installed to replace the non-functioning light in the boiler room.

The facility has conducted a testing of all emergency lighting.

ID of Others

The M Dir will conduct an audit of all emergency lighting to inspect for proper function. The audit will occur before the date of compliance.

Systemic Change

The M Dir will be educated by the NHA/Designee in regard to the Life Safety code and the requirements of conducting emergency lighting tests on a monthly and annual basis. The education will occur before the date of compliance.

Monitoring

The monitoring will follow the corrective action in that the emergency lighting will need to be tested monthly and the results of the audits will be presented at the QAPI meeting for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 062 – Sprinkler Systems

Corrective Action

The obstruction in the Therapy Closet was removed by the M Dir and allows the head to function properly.

ID of Others

The M Dir will conduct an audit before the date of compliance for all closets in the home to ensure that the sprinkler coverage is not obstructed.

Systemic Change

The Rehab team members who are in charge of the space will receive education in regard to the Life Safety code from the NHA/Designee as to what is acceptable in the storage area for the sprinklers to function properly. The education will occur before the date of compliance.

Monitoring

The M Dir will conduct an audit of all public use closets to ensure that closet areas are not obstructed in regard to sprinkler coverage. This audit will occur monthly for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 066 – Smoking regulations

Corrective Action

The combustible ashtrays were removed.

The cigarette butts were removed from the Maintenance Shed.

The plastic bucket was removed from the smoking area and will be replaced with proper ashtrays for the area.

The wooden barrel was removed from the area during the survey.

ID of Others

The M Dir will conduct an audit of the current resident smoking area as well as the current staff smoking area (next to the Maintenance Shed) to ensure all ashtrays meet Life Safety requirements. The audit will occur before the date of compliance.

Systemic Change

Education will be provided to the M Dir in regard to the LS code surrounding acceptable items for use in a smoking area. The education will be provided by the NHA/Designee and occur before the date of compliance.

Monitoring

The NHA/designee will conduct a monthly audit of the resident smoking area and the staff smoking area to ensure that the areas remain free from unacceptable items per the LS code. The audits will occur for 3 months to ensure the sustained changes. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 106 - Generator

Corrective Action

A proper switch cover was ordered for the Generator button and will be installed upon arrival.

ID of Others

The M Dir will inspect all Generator switches in the home to ensure they meet the proper requirements. The review will occur before the date of compliance.

Systemic Change

The M Dir will receive education in regard to the requirements for a generator by the NHA/Designee before the date of compliance.

Monitoring

The M Dir will conduct a monthly audit for 3 months to confirm that the changes made have been sustained and that the switches still work properly. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 143 – Oxygen Transfer

Corrective Action

A CGA pamphlet will be emailed by the Life Safety surveyor so that the home can place them in the oxygen transfer room.

ID of Others

The M Dir will audit all Oxygen transfer rooms to ensure that each room has PPE and a CGA pamphlet.

Systemic Change

Education will be provided to facility staff in regard to the requirements and use of PPE during an oxygen transfer. The education will be provided before the date of compliance by the NHA/Designee.

Monitoring

The M Dir will conduct an audit of Oxygen transfer rooms to ensure that the CGA pamphlet remains and that the PPE is in the room. The audits will be monthly for a period of 3 months to sustain the changes.

Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15

K 144 – Generator Inspection

Corrective Action

The facility has conducted a test of the generator.

ID of Others

The M Dir will conduct an audit of all generators in the facility to ensure that each is tested on the proper cycle. The audit will occur before the date of compliance.

Systemic Change

The M Dir will receive education before the date of compliance in regard to the proper need for generator testing per the LS code. The education will be provided by the NHA/Designee.

Monitoring

The M Dir will continue to test the generator monthly as required and bring the reviews each month to QAPI for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date 7/23/15
