PRINTED: 06/26/2015
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0005	A. BUILDING: _____ 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) COMPLETE DATE
S 000	General Comments A Life Safety Code survey was conducted at your facility on June 15, 2015 by the office of Healthcare Licensing and Surveys. (HLS) 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. Wyoming Department of Health, Rules and Regulations for Licensure of Nursing Care Facilities Chapter 19, Section 8 Life Safety and Electrical Safety. The requirements in the Department of Health Chapter III, Construction Rules for Health Facilities apply.	S 000	**Cheyenne Health Care Center-State Life Safety Survey –6/15-6/18/2015–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 of 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.	
S7015	NFPA Life Safety - Nfpa Prot from Hazards NFPA 101 Protection from Hazards This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medical gas storage areas are protected in accordance to the 2006 International Building Code (IBC) in 2 of 6 smoke compartments. The findings were: 1. Observation of the oxygen storage room on the south west corridor on 06/15/15 at 10:58 AM revealed (12) large 41 liter liquid oxygen tanks, (10) E cylinders, and (6) M6 cylinders of compressed gas. The total cubic feet of oxygen located in the room was approximately 15,207 cubic feet. Further observation revealed the room	S7015	S 7015 Corrective Action The home has proposed a new oxygen transfer area within the home that fully meets all NFPA and Life Safety Standards. The project is presently awaiting approval from the Office of Healthcare Licensing and Surveys. The plan was submitted back in late March and was given an extension of 10/1/15 for a completion date. The company has approved the expense for the room once the approval is given from the Licensing board. ID of Others The NHA/Designee will conduct an audit of the facility to locate any rooms in which oxygen is stored or transferred. The audit will occur before the date of compliance.	

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 7/10/15

STATE FORM 6899 ROWR11 If continuation sheet 1 of 4

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WY Department of Health
JUL 10 2015
Healthcare Licensing and Surveys

POC Accepted Via Phone Call with the Administration JohnStewart on 7/10 @ 1:46pm
34354

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S7015	Continued From page 1 had an 1 hour separation in lieu of the required 2 hour separation in accordance to the 2006 IBC. At the time of the observation the facility maintenance manager acknowledged the amount of oxygen stored in the room, and the existing 1 hour separation. 2. Observation of the oxygen storage room on the north corridor on 06/15/15 at 2:26 PM revealed (8) large 41 liter liquid oxygen tanks. The total cubic feet of oxygen located in the room was approximately 9,955 cubic feet. Further observation revealed the room had an 1 hour separation in lieu of the required 2 hour separation in accordance to the 2006 IBC. At the time of the observation the facility maintenance manager acknowledged the amount of oxygen stored in the room, and the existing 1 hour separation. 3. Observation on 06/15/15 from 10:58 AM to 2:26 PM of both oxygen storage rooms revealed the total amount of stored oxygen in the building was approximately 25,100 cubic feet. Storage locations exceeding 20,000 cubic feet are defined by NFPA99 as bulk oxygen systems and therefore must comply with NFPA 55. At the time of the observations the facility maintenance manager acknowledged the amount of oxygen being stored in the building. Ref: 2006 IBC, Tables 307.1(1), 508.3.3, and Section 307.5 2005 NFPA 99, sections 3.3.19.2 and 5.1.3.4.13.1 2003 NFPA 55, sections 6.3.1, table 6.3.1, 6.5, and table 6.5	S7015	Systemic Change Education will be provided to the facility Maintenance Director before the date of compliance by the NHA/Designee. The education will focus on the necessary protocols for oxygen transfer rooms. Monitoring The NHA/Designee will conduct a monthly audit to inspect for any oxygen storage in rooms beyond the approved areas. The 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 8-13-15 S 7036 Corrective Action The home has ordered an ASSE 1071-Mixing Valve for both eye wash stations. The parts will be installed upon receipt of the items. ID of Others The Maintenance Director will conduct an audit of all eye wash stations in the home to ensure that the	

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S7036	Continued From page 2	S7036	homes are properly equipped with the approved Pre Mix valves as required.	
S7036	IPC Life Safety - Int'l Plumbing Code This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the existing plumbing systems in a manner that is in accordance with the WDH Chapter 3 Construction Rules and Regulations for Healthcare Facilities, in accordance with the original design, and in a safe and sanitary condition. The findings were: Observation of the two emergency eyewash stations located in the north and south soiled utility rooms on 06/15/15 from 11:56 AM to 2:21 PM revealed that tepid water was not provided to the eyewash via an ASSE 1071 - Performance Requirements for Temperature Actuated Mixing Valves for Plumbed Emergency Equipment - mixing valve in compliance with ANSI Z358.1 - Standard for Emergency Eye Wash and Shower Equipment. An interview with the facility maintenance manager at the time of the observations confirmed that the eyewash was not provided with a tempering valve in compliance with the requirements of ANSI Z358.1. (Reference 2006 IPC, Section 411) Ref: 2006 IPC, Sections, 411, 608.6, and 608.13	S7036	Systemic Change Education will be provided to the Maintenance Director by the NHA/Designee in regard to the requirements for proper eye wash stations in the facility. The education will be provided before the date of compliance. Monitoring The NHA/Designee will conduct a monthly audit of all eye wash stations to ensure the eye wash stations are maintaining proper function. The 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 8-13-15	
S7999	State Miscellaneous Life Safety State Miscellaneous This STANDARD is not met as evidenced by: Based on observation and staff interview, the	S7999	S 7999 Corrective Action The peeling paint was removed completely and repainted by facility Maintenance staff members before the date of compliance.	

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S7999	Continued From page 3 facility failed to maintain the building per WDH Chapter 8 guidelines. The finding were: Observation of resident room #121 on 06/15/15 at 11:15 AM revealed a section of paint peeling from the ceiling directly above the residents bed. Interview with the facility maintenance manager acknowledged the peeling paint. Ref: WDH Chapter 11, Section 6	S7999	ID of Others As a cross reference to Health Dept survey tag 253, the home will be conducting an audit of all resident rooms to ensure that the issues in the rooms are rectified. This audit will include inspections for peeling paint. Items will be resolved before the date of compliance. Systemic Change Education will be provided to the Maint Director in regard to proper regular care and maintenance of painting the resident rooms. The education will be provided by the NHA/Designee before the date of compliance. Monitoring The NHA/Designee will conduct an audit of resident rooms monthly for the 3 months to inspect for proper paint coverage in the resident rooms. 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 8-13-15	

Cheyenne Health Care Center- State Life Safety Survey –6/15-6/18/2015–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 of 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.

S 7015

Corrective Action

The home has proposed a new oxygen transfer area within the home that fully meets all NFPA and Life Safety Standards. The project is presently awaiting approval from the Office of Healthcare Licensing and Surveys. The plan was submitted back in late March and was given an extension of 10/1/15 for a completion date. The company has approved the expense for the room once the approval is given from the Licensing board.

ID of Others

The NHA/Designee will conduct an audit of the facility to locate any rooms in which oxygen is stored or transferred. The audit will occur before the date of compliance.

Systemic Change

Education will be provided to the facility Maintenance Director before the date of compliance by the NHA/Designee. The education will focus on the necessary protocols for oxygen transfer rooms.

Monitoring

The NHA/Designee will conduct a monthly audit to inspect for any oxygen storage in rooms beyond the approved areas. The 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 8-13-15

S 7036

Corrective Action

The home has ordered an ASSE 1071- Mixing Valve for both eye wash stations. The parts will be installed upon receipt of the items.

ID of Others

The Maintenance Director will conduct an audit of all eye wash stations in the home to ensure that the homes are properly equipped with the approved Pre Mix valves as required.

Systemic Change

Education will be provided to the Maintenance Director by the NHA/Designee in regard to the requirements for proper eye wash stations in the facility. The education will be provided before the date of compliance.

Monitoring

The NHA/Designee will conduct a monthly audit of all eye wash stations to ensure the eye wash stations are maintaining proper function. The 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 8-13-15

S 7999

Corrective Action

The peeling paint was removed completely and repainted by facility Maintenance staff members before the date of compliance.

ID of Others

As a cross reference to Health Dept survey tag 253, the home will be conducting an audit of all resident rooms to ensure that the issues in the rooms are rectified. This audit will include inspections for peeling paint. Items will be resolved before the date of compliance.

Systemic Change

Education will be provided to the Maint Director in regard to proper regular care and maintenance of painting the resident rooms. The education will be provided by the NHA/Designee before the date of compliance.

Monitoring

The NHA/Designee will conduct an audit of resident rooms monthly for the 3 months to inspect for proper paint coverage in the resident rooms. 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 8-13-15