RECEIVED
WY Dept of Health
OCT 01 2015
Licensing and Surveys

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

PRINTED: 09/18/2015
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
	535013	A. BUILDING _____ B. WING _____	08/31/2015

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. 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 80.	K 000		
K 029 SS=D	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 facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 2 of 12 smoke compartments. The findings	K 029	K029 Corrective Action: Self-closing devices were added to the doors of the central supply storage room and kitchen. Identification of Others: The maintenance director will perform a facility-wide audit to ensure that all necessary areas have self-closing devices on the doors. System Changes: The maintenance director will perform QA audits to ensure that the closers are in place and functioning. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. Monitoring: Results from audits will be reported at monthly QA meetings	10/18/2015

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

Administrator 9/28/15

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.

modified POC Accepted via Phone with Adam Zanger Administrator on 10/14/2015 @ 2:10pm 34354

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 _____	08/31/2015

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 029	Continued From page 1 were: 1. Observation on 08/31/15 at 10:36 AM revealed the corridor door to the central supply storage room was not provided with self-closing device. At the time of the observation the Facility Maintenance Manager acknowledged the door was not provided with self-closing device. 2. Observation on 08/31/15 at 11:55 AM revealed both kitchen doors to the dining room were not provided with a self-closing devices. At the time of the observation the Facility Maintenance Manager acknowledged the doors were not provided with a self-closing devices. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange protected stairwells in a way to avoid the potential to interfere with egress. The findings were: Observation of the south basement protected	K 033	K033 Corrective Action: All items being stored in the south basement stairwell have been removed. Identification of Others: The maintenance director will perform a facility-wide audit to ensure that all stairwells do not have items being stored.	10/18/2015

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 _____	08/31/2015

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 033	Continued From page 2 stairwell on 08/31/15 at 9:56 AM revealed a 2.5 gallon bucket, 3 boxes, and a wood storage cabinet being stored inside the stairwell on the basement level. At the time of the observation the Facility Maintenance Manager acknowledged the items being stored inside the stairwell. Ref: 2000 NFPA 101, Sections 19.2.2.3, 7.2.2.1, 7.1.3.2.3, and 7.2.2.5.3	K 033	System Changes: The maintenance director will perform QA audits to ensure that the stairwells are free from storage items. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. Monitoring: Results from audits will be reported at monthly QA meetings	
K 038 SS=E	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 arrange exit access so that exits are readily accessible at all times in 5 of 12 smoke compartments. The findings were: 1. Observation on 08/31/15 at 10:26 AM revealed the basement corridor was being utilized for storage. A table, two dressers, and cleaning supplies in boxes were observed in the corridor. At the time of the observation the Facility Maintenance Manager acknowledged the items being stored in the corridor. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.5.1.1 2. Observation on 08/31/15 at 10:32 AM revealed	K 038		

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 _____	08/31/2015

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 038	Continued From page 3 the outside door fire exit from the business office required more than 15lbf of force to activate the releasing hardware, and more than 30lbf to open the door to full use. At the time of the observation the Facility Maintenance Manager acknowledge the force needed to open the door. 3. Observation on 08/31/15 at 10:56 AM revealed the courtyard gate required more than 15lbf of force to activate the releasing hardware on the gate. At the time of the observation the Facility Maintenance Manager acknowledge the force needed to unlatch the gate. 4. Observation on 08/31/15 at 11:06 AM revealed the west emergency stairwell exit door located in the TCU required more than 15lbf of force to activate the delayed egress hardware. At the time of the observation the Facility Maintenance Manager acknowledge the excess force needed to activate the delayed egress hardware. 5. Observation on 08/31/15 at 11:45 AM revealed the first floor dining room exit door required more than 15lbf of force to activate the delayed egress hardware. At the time of the observation the Facility Maintenance Manager acknowledge the excess force needed to activate the delayed egress hardware. 6. Observation on 08/31/15 at 2:43 PM revealed the third floor west fire exit door required more than 15lbf of force to activate the delayed egress hardware. At the time of the observation the Facility Maintenance Manager acknowledge the excess force needed to activate the delayed egress hardware. Ref:	K 038	K038 Corrective Action: All items being stored in the basement corridor have been removed. Additionally all doors noted, including business office fire exit, courtyard gate, west emergency stairwell, first floor dining room exit and third floor fire exit have had the tension reduced as to allow for less than 15 pounds of force to open. The pad lock was removed from the central supply storage room door and no longer contains a double lock. The manual slide lock on the rehab exit door to TCU has been removed. Identification of Others: The maintenance director will perform a facility-wide audit to ensure that all corridors do not have items being stored. All doors will be checked to ensure they do not require more than 15 pounds of force to open. All doors will also be checked for double locks and unapproved slide locks. System Changes:	10/18/2015

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 _____	08/31/2015

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 038	Continued From page 4 2000 NFPA 101, Sections 19.2.2.2.1, 7.2.1.4.5, and 7.2.1.6.1 7. Observation on 08/31/15 at 10:35 AM revealed the central supply storage room door was double locked. A second padlock was located approximately 42" above the floor. At the time of the observation the Facility Maintenance Manager acknowledged the second lock on the door. 8. Observation on 08/31/15 at 11:15 AM revealed the rehab exit door to the TCU was equipped with a manual slide hinge lock located approximately 72 inches above the floor on the double doors. When the lock was engaged, the required exit doors would not open impeding egress. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	The maintenance director will perform QA audits on these items. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. Monitoring: Results from audits will be reported at monthly QA meetings	
K 052 SS=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:	K 052	K052 Corrective Action: Sensitivity testing had been completed on the smoke alarms throughout the facility. This is a function that is completed by the fire system through internal checks. The technician has printed out those reports that indicate the sensitivity testing has been completed as required. Identification of Others: The maintenance director will ensure that all necessary documentation is accessible	10/18/2015

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 _____	08/31/2015

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 052	Continued From page 5 Based on document review and staff interview, the facility failed to provide documentation to indicate that the fire alarm systems have been tested in accordance with NFPA 72. The findings were: Document review on 08/31/15 at 3:30 PM regarding the testing and maintenance of the fire alarm system revealed the lack of sensitivity testing of the smoke alarms throughout the facility. Documentation provided shows the last sensitivity testing was completed on 02/14/2013. Ref: 2000 NFPA 101, Sections 19.3.4.1 and 9.6.1.4 1999 NFPA 72, Section 7-3.2.1	K 052	System Changes: The maintenance director/designee will conduct an audit to confirm that sensitivity testing in completed in accordance with NFPA 72 Monitoring: Results from audits will be reported at monthly QA meetings	
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 protect the building throughout by	K 056	K056 Corrective Action: The housekeeping closet on the first floor will have a sprinkler head installed. Identification of Others: The maintenance director will complete audit to ensure that all necessary areas of the building are sprinkled. System Changes: Any new additional areas of the building that are not sprinkled will be evaluated for the appropriateness of adding a sprinkler head.	~~2/1/2016~~ 10/18/15

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 _____	08/31/2015

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 056	Continued From page 6 an approved, supervised automatic sprinkler system. Observation on 08/31/15 at 2:10 PM revealed that sprinkler heads were not installed in the housekeeping closet on the first floor. Interview with the Facility Maintenance Manager during the observation acknowledged the non-sprinklered area. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 1-6.1	K 056	Monitoring: ED/designee will ensure that engineer reports and recommendations are carried out to meet all necessary regulations.	
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, document review and staff interview, the facility failed to ensure that automatic sprinkler systems are continuously maintained per the requirements of NFPA 13 and NFPA 25. The finding were: 1. Observation of the Sprinkler Riser in the basement and in the transitional care unit on 08/31/15 at 10:17 AM and 10:55 AM revealed no hydraulic calculations posted at or near the risers. At the time of the observations the Facility Maintenance Manager acknowledged the hydraulic calculations were not posted. Ref: 2000 NFPA 101, Sections 19.3.5.1, 19.1.6.2, and	K 062	K062 Corrective Action: The sprinkler risers in the basement and transitional care unit will have hydraulic calculations posted. The ceiling tiles located in medical records, central supply and accounting/payroll have been replaced. Identification of Others: The maintenance director will complete audit to ensure that all sprinkler risers have calculations posted at or near the area and all ceiling tiles are in place. System Changes: The maintenance director will perform QA audits to ensure that the calculations and ceiling tiles remain in place. These will be performed	~~11/1/2015~~ 10/18/15

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 _____	08/31/2015

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 062	Continued From page 7 9.7.1.1 1999 NFPA 13, Section 10-5 2. Observation on 08/31/15 from 10:01 AM to 10:48 AM revealed missing ceiling tiles in the following areas with a resulting open area around the sprinkler heads greater than 12 inches from the ceiling. Medical records missing 5 ceiling tiles, central supply missing 4 ceiling tiles, and accounting and payroll office missing 1 ceiling tile. The Facility Maintenance Manager verified the missing ceiling tiles at the time of the observations. Ref: 2000 NFPA 101, Sections 19.3.5.1, 9.7.1.1, and 9.7.5 1999 NFPA 13, Section 5-6.4.1.1 1998 NFPA 25, Sections 2-2.1.1 and 2-2.7	K 062	monthly for 3 months, then bi-monthly for 6 months thereafter Monitoring: Results from audits will be reported at monthly QA meetings. The date of compliance for the installation of the cited ceiling tiles in 10/18/2015.	
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 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:	K 076	K076 Corrective Action: New door hardware has been placed on the Oxygen Storage Room in the transitional care unit. The door is now able to latch and the penetration no longer exists. Identification of Others: The maintenance director will complete facility-wide audit to ensure that all doors are able to latch and are free from penetrations.	10/18/2015

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 _____	08/31/2015

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 076	Continued From page 8 Based on observation and staff interview, the facility failed to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99. The findings were: Observation of the Oxygen Storage Room in the transitional care unit on 08/31/15 at 11:05 AM revealed no door hardware on the self-closing door. A 3 inch round hole was penetrating the door, and the door was not capable of being latched into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door was unable to latch, and the missing hardware on the door creating the penetration. Ref: 1999 NFPA 99, Section 4-3.1.1.2 (2)	K 076	System Changes: The maintenance director will perform QA audits to monitor doors for penetrations and ability to latch. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. Monitoring: Results from audits will be reported at monthly QA meetings.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide patient care-related equipment with special purpose relocatable power taps that are UL 1363A or 60601-1. The findings were: Observation on 08/31/15 from 1:32 PM to 2:20 PM revealed oxygen concentrators plugged into non-medical grade power taps in the following locations. Resident rooms #221, #222, #307, #308, and #311. At the time of the observations the Facility Maintenance Manager acknowledged	K 130		

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 _____	08/31/2015

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 130	Continued From page 9 the use of the non-medical grade power taps in the resident rooms to power oxygen concentrators. Ref: S&C 14-46-LSC	K 130	K130 Corrective Action: Oxygen concentrators in rooms 221, 222, 307, 308 and 311 are now plugged into medical grade power taps (wall outlets). Identification of Others: The maintenance director will complete facility-wide audit to ensure that all room concentrators are plugged into medical grade power taps (wall outlets). System Changes: The maintenance director will perform QA audits to monitor concentrators in rooms for proper outlet usage. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. Monitoring: Results from audits will be reported at monthly QA meetings.	10/18/2015