STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/15/2016

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
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 (111) construction separated by five, 2-hour rated fire barriers with plan approval in 1987 and 2009. 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 128 residents.	K 000		
K 038 SS=D	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 2 of 7 smoke compartments. The findings were: 1. Observation on 03/15/16 at 10:25 AM revealed the courtyard exit gate to the public way had been broken and was inoperable. Interview with the Facility Maintenance Manager and the Facility Administrator at the time of the observation revealed the gate had been broken this winter, and they were in the process of having it repaired. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.5.1.1	K 038	K038 Exit access is arranged so that exits are readily accessible at all times. A) Courtyard exit gate was repaired on 3/16/16. Front entrance horizontal sliding doors were no longer labeled as an exit on 4/8/16. Service entrance corridor exit door's delayed egress scheduled for repair on 4/11/16 and a visible sign indicating the door was a delayed egress door will be placed on 4/11/16. B) The maintenance director will randomly observe the courtyard gate to ensure it functions correctly. The maintenance director will randomly observe facility exits to ensure they are labeled correctly and that all delayed egress doors function properly.	4/18/16 ~~5/1/2016~~ 49

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director — TITLE — (X6) DATE: 4/8/16

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 Accepted via Phone call with The Administrator Bryan Merrell on 4/18/16 @ 3:08pm 34354

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	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

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K 038	Continued From page 1 2. Observation on 03/15/16 at 1:10 PM revealed the front entrance horizontal sliding doors were labeled as an exit. Further observation revealed the doors were provided with a keyed lock, and would not open without the use of a red push button located at the reception desk. At the time of the observation the Facility Maintenance Manager and the Facility Administrator both acknowledged the doors were locked and labeled as an exit. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.2.1.5.1 3. Observation on 03/15/16 at 1:40 PM revealed the service entrance corridor exit door was provided with a keypad, and was locked from the egress side. Further observation revealed the exit door was provided with delayed egress that would not activate when 15 pounds force of pressure was applied to the door. It was also noted at the time of the observation that no readily visible sign indicating the door was delayed egress was present. Interview with the Facility Maintenance Manager confirmed the door was locked, and the delayed egress was not functioning. Ref: 2000 NFPA 101, sections 19.2.1 and 7.2.1.6.1	K 038	C) Maintenance staff will report quarterly at the Performance Improvement meeting the findings of their observations. This will happen for one quarter or until substantial compliance has been achieved.	
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:	K 062	K062 Required automatic sprinkler systems are continuously maintained in reliable operating condition.	4/18/16 ~~5/1/2016~~

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K 062	Continued From page 2 Based on observation and staff interview, the facility failed to ensure that automatic sprinkler systems are installed and continuously maintained per the requirements of NFPA 13 in 3 of 7 smoke compartments. The finding were: Observation on 03/15/16 from 11:20 AM to 12:10 PM revealed missing escutcheon rings with a resulting gap around the sprinkler head in the following locations: clean linen room adjacent to room #408, nursing station #5, medication room #5, room #509, and room #11. At the time of the observations the Facility Maintenance Manager acknowledged the missing escutcheon rings. Ref: 2000 NFPA 101, Sections 18.3.5.1, 19.3.5.1, and 9.7.1.1 1999 NFPA 13, Section 3-2.7.2	K 062	A) The facility replaced missing escutcheon rings in the clean linen room adjacent to room #408, nursing station #5, medication room #5, room #509, and room #11 on 3/15/16. B) The maintenance director will randomly observe sprinkler heads to ensure that escutcheon rings are in place throughout the facility. C) The maintenance staff will report quarterly at the Performance Improvement meeting the findings of their observations. This will happen for one quarter or until substantial compliance has been achieved.	