STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MAIN BUILDING B. WING	09/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	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 Nursing Homes 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 Type II(111) construction built in 1966 and 1972. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 148 certified Medicare and Medicaid beds with a census of 104.	K 000	Preparation and execution of the response and plan of correction does not constitute an 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 the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by:	K 018	K 018 1. The Maintenance Director or designee repaired the electrical equipment room and shower room door penetration on the 100 corridor on or before 10/05/2016.	10/05/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: Updated on 10/10/2016 Original Submission 10/03/2016.

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.

Accepted Plan of Correction on 10/20/2016 via phone call with Lea Lowe.

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K 018	Continued From page 1 Based on observation and staff interview, the facility failed to provide doors that were in accordance with NFPA 101. The findings were: Observation on 09/06/2016 from 9:30 AM to 9:45 AM revealed doors that were incapable of resisting the passage of smoke located in the 100 corridor in the electrical equipment room, and the community bath room. Further observation revealed missing hardware to open and/or latch the doors as well as holes penetrating the doors approximately 2 inches in diameter located where the latching hardware would normally be. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing door handles and the penetrations. Ref: 2000 NFPA 101, Section 19.3.6.3.6	K 018	2. The Maintenance Director or Designee to complete an audit of corridor doors on or before 10/05/2016 to ensure that corridor doors don't have holes where the latching hardware would normally be. 3. The Maintenance Director or Designee will randomly audit doors two (2) times per week for four (4) weeks then weekly until substantial compliance has been achieved to ensure any newly discovered areas are repaired. 4. The Maintenance Director or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 protect against hazardous areas in accordance with NFPA 101. The findings were: 1. Observation on 09/06/2016 from 9:30 AM to 9:45 AM located in the 100 corridor in the soiled	K 029	K 029 1. The Maintenance Director or Designee repaired the soiled utility room and the oxygen storage room door penetration on the 100 corridor on or before 10/05/2016.	10/05/2016

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K 029	Continued From page 2 utility room, and the oxygen storage room revealed doors missing hardware to open and/or latch the doors. Further observation revealed the doors were incapable of resisting the passage of smoke/fire with penetrations approximately 2 inches in diameter located where the latching hardware would normally be. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing door handles and the hole penetrations. 2. Observation on 09/06/2016 from 9:20 AM to 9:45 AM located in rooms 108, 109 114, 113 revealed that the rooms were being utilized as storage rooms and not resident rooms. Further observation revealed mattresses and/or furniture in excess of a typical living space of a two residents. The area of the storage was greater than 50 square feet and missing a door closer device on the door to the corridor. Interview with the Facility Maintenance Manager at the time of observation acknowledged the use of space as storage without a door closing device. 3. Observation on 09/06/2016 at 1:44 PM located at the 2nd and 3rd floor trash room doors revealed that the doors would not self-latch. Further observation of the 2nd floor door revealed 2 penetrations approximately 1 inch in diameter that would not resist the passage of smoke/fire. Interview with the facility Maintenance Manager at the time of observation acknowledged both doors would not latch and acknowledged the penetrations for the 2nd floor trash room door. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	The Maintenance Director or Designee removed items in rooms #108, #109, #114 and #113 that were in excess of a typical living space of two (2) residents on or before 10/05/2016. The Maintenance Director or Designee repaired the 2nd and 3rd floor trash room doors on or before 10/05/2016 to ensure they self-latch and repaired the 2nd floor trash room door penetration. 2. The Maintenance Director or Designee to complete an audit of trash room corridor doors on or before 10/05/2016 to ensure that corridor doors don't have penetration and are able to self-latch. 3. The Maintenance Director or Designee will randomly audit doors two (2) times per week for four (4) weeks then weekly, until substantial compliance has been achieved to ensure any newly discovered areas are repaired.	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=E	Continued From page 3 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 exits that are readily accessible at all times in accordance with NFPA 101. The findings were: 1. On 09/06/2016 at 8:58 AM located in the 100 corridor adjacent to the rehab room revealed an exterior door leading south to the outside that required more than 30 pounds of force to set the door in motion. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the door exceeded 30 pounds of force to set the door in motion. 2. On 09/06/2016 at 9:11 AM located in the 100 corridor revealed an exterior door leading to the courtyard that required more than 30 pounds of force to set the door in motion. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the door exceeded 30 pounds of force to set the door in motion. 3. On 09/06/2016 at 2:50 PM located at the South Exit Stair Well Exit Door to the public way required more than 30 pounds of force to set the door in motion. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the force exceeded 30 pounds to set the door in motion. Ref: 2000 NFPA 101, Sections 19.2.1 And 7.2.1.4.5	K 038	4. The Maintenance Director or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. K 038 1. The Maintenance Director or Designee will repair the exit door leading south to the outside on the 100 corridor, the exterior door leading to the courtyard in the 100 corridor and the south exit stairwell door to the public way to ensure that the doors are readily accessible on or before 01/23/2017. The Maintenance Director or Designee will apply the proper signage to the east exit door indicating the use of the delayed egress locking system on or before 10/05/2016. The Maintenance Director or Designee will repaired the cross corridor doors to allow the door and door hardware to	10/05/2016 01/23/2017 Request for timeline waiver

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K 038	Continued From page 4 4. Observation on 09/06/2016 10:09 AM revealed the east exit door was equipped with delayed egress and that the proper signage was missing indicating the use of the delayed egress locking system. Interview with the Facility Maintenance Manager at the time of observation acknowledged they were unaware of this requirement. Ref: 2000 NFPA 101, Sections 19.2.1 And 7.2.1.6.1 5. Observation on 09/06/2016 at 1:20 PM located in the secure unit revealed that the cross-corridor doors at the smoke compartment wall in the egress path from the secure unit had been painted with a mural, which rendered the doors unrecognizable by a non-impaired person, such as a visitor. Additional observation revealed that the doors were locked with keypad access by staff at all times, which also resulted in minimal door opening hardware on the doors to aid in recognition Opening hardware was limited to handles on the door, which had also been painted as part of the mural. Interview with the Facility Maintenance Manager at the time of observation acknowledged they were unaware of the requirement to maintain a recognizable means of egress to non-impaired persons. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1 S&C Letter 07-07 6. Observation on 09/06/2016 at 10:34 AM located outside the dining room east exit were 3 sand bags positioned in such a way that it obstructed egress to the public way. Interview with Facility Maintenance Manager at the time of	K 038	be recognizable as a door on or before 10/05/2016. The Maintenance Director or Designee will remove the sand bags outside of the 1st floor dining room to allow for an appropriate egress to the public way on or before 10/05/2016. The Maintenance Director or Designee will repair the Maintenance office door to allow for a one releasing operation to make the door operable on or before 10/05/2016. At this time we are requesting a time limited waiver through 01/23/2017. 2. The Maintenance Director or Designee will complete an audit of Exit access doors to ensure that the doors are readily accessible on or before 10/05/2016. The Maintenance Director or Designee to complete an audit of delayed egress locking system doors to ensure doors	

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K 038	Continued From page 5 observation acknowledged the facility was obstructing the path way. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.7.2 7. Observation on 09/06/2016 at 2:50 PM revealed that the Maintenance Office door was equipped with a dead bolt lock that required more than one releasing operation to make the door operable. Interview with the Facility Maintenance Manager at the time of observation acknowledged the door lock required more than one operation to open. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 8. Observation on 09/06/2016 at 9:13 AM located at the north courtyard ramp to the public way revealed that the ramp had a rise approximately 15 inches with only one set of handrails. Interview with the Facility Maintenance Manager at the time of observation was unaware that a ramp with rise greater than 6 inches requires a hand rail on each side of the ramp. 9. Observation on 09/06/2016 at 10:34 AM located outside the dinning east exit doors revealed a ramp that had a rise greater than 6 inches and a run at approximately 15 inches. Interview with the Facility Maintenance Manager at the time of observation was unaware of the maximum slope requirement for a Class B existing ramp of 1 in 8 units or 12 percent slope.	K 038	have proper signage posted on or before 10/05/2016. The Maintenance Director or Designee to complete an audit of cross corridor doors to ensure door and door hardware are recognizable as a door on or before 10/05/2016. The Maintenance Director or Designee to audit exit doors to the public way to allow for an appropriate egress to the public way on or before 10/05/2016. At this time we are requesting a time limited waiver through 01/23/2017. 3. The Maintenance Director or Designee will randomly audit exit doors one (1) time per week for four (4) weeks then weekly, until substantial compliance has been achieved to ensure any newly discovered areas are repaired. The Maintenance Director or Designee will randomly audit one (1) time per week for four	

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K 038	Continued From page 6 10. Observation on 09/06/2016 at 2:51 PM located outside the South Exit Stair Well Exit door to the public way revealed a ramp that had a rise approximately 10 inches and a run approximately 72 inches. Further observation revealed the bottom landing to be approximately 10 inches and no hand rails were provided for the ramp. Interview with the Facility Maintenance Manager at the time of observation was unaware of the maximum slope requirement for a Class B ramp of 1 in 8 units. The facility was also unaware of the minimum 60 inch bottom landing and the requirement for hand rails on each side for a rise greater than 6 inches. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.2.5	K 038	(4) weeks then weekly, until substantial compliance has been achieved delayed egress locking system doors to ensure doors have proper signage posted on or before. The Maintenance Director or Designee to complete an audit one (1) time per week for four (4) weeks then weekly, until substantial compliance has been achieved of cross corridor doors to ensure door and door hardware are recognizable as a door.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide exit and directional signs in accordance with NFPA 101. The findings were: 1. Observation on 09/06/2016 at 9:10 AM located in the 100 corridor facing north from the Nurses Station revealed an exit sign that was not illuminated adjacent to rooms 105 and 106. Interview with the Facility Maintenance Manager at the time of observation acknowledged the sign was not illuminated.	K 047	The Maintenance Director or Designee to audit one (1) time per week for four (4) weeks then weekly, until substantial compliance has been achieved exit doors to the public way to allow for an appropriate egress to the public way. At this time we are requesting a time limited waiver through 01/23/2017. 4. The Maintenance Director or Designee will report results of the audit to the facility monthly Quality Assurance	

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	535013	A. BUILDING 01 - MAIN BUILDING B. WING	09/07/2016

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K 047	Continued From page 7 2. Observation on 09/06/2016 at 9:35 AM located in the 100 corridor adjacent to patient room 112 facing north-west revealed a missing exit sign to show a second means of egress. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing exit sign. 3. Observation on 09/06/2016 at 9:40 AM revealed a vinyl exit sign on a column adjacent to the elevator banks and the soda beverage machine. Further observation revealed that the exit sign was not illuminated. Interview with the Facility Maintenance at the time of observation acknowledged the sign was not illuminated. Ref: 2000 NFPA 101, Sections 19.2.10.1 and 7.10.7.2	K 047	Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. At this time we are requesting a time limited waiver through 01/23/2017. K 047 1. The Maintenance Director or Designee installed illuminated exit signs adjacent to rooms #105 and #106, adjacent to room #112 and adjacent to the elevator bank on or before 10/05/2016. 2. The Maintenance Director or Designee to complete an audit of Illuminated Exit signs to ensure signs are illuminated on or before 10/05/2016. 3. The Maintenance Director or Designee will randomly audit exit signs one (1) time per week for four (4) weeks then weekly, until substantial compliance has been achieved to ensure exit signs are illuminated. 4. The Maintenance Director or Designee will report results of the audit to the facility	10/05/2016
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10. The findings were: Observation on 09/06/2016 at 9:15 AM located in the 100 corridor across from room 106, and in the maintenance office revealed a fire extinguisher approximately 65 inches mounted from the top of the extinguisher to the ground. Interview with the Facility Maintenance Manager at the time of observation was unaware of the height requirement.	K 064		

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	535013	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/07/2016

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K 064	Continued From page 8 Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1998 NFPA 10, Section 1-6.10	K 064	monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	
K 130 SS=D	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 1363A or UL 60601-1. The findings were: Observation on 09/06/2016 at 11:06 AM located in rooms, 206 and 222 revealed oxygen concentrators plugged into non-medical grade power taps. At the time of observation the Facility Maintenance Manager acknowledged 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	K 064 1. The Maintenance Director or Designee properly mounted the fire extinguisher located across of room #106 on or before 10/05/2016. 2. The Maintenance Director or Designee to audit fire extinguishers to ensure they are mounted to the appropriate height on or before 10/05/2016.	10/05/2016
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to meet electrical wiring in accordance with NFPA 70. The findings were: 1. Observation on 09/06/2016 from 9:09 AM to 9:20 AM located in room 103, 104, 106, 114 and throughout the 100 corridor rooms and areas revealed a receptacles approximately 2 feet away	K 147	3. The Maintenance Director or Designee will randomly audit fire extinguishers one (1) time per week for four (4) weeks then weekly, until substantial compliance has been achieved to ensure appropriate height mounting. 4. The Maintenance Director or Designee will report results of	

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K 147	Continued From page 9 from sinks that were not equipped with a ground-fault circuit-interrupters. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupters. 2. Observation on 09/06/2016 at 11:06 PM located at room 201 revealed a receptacle within approximately 2 feet from the sink without a ground-fault circuit-interrupter. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupter. Ref: 1999 NFPA 70, Article 210.8 3. Observation on 09/06/2016 at 1:45 PM revealed that the facility could not demonstrate they had a remote annunciator for their generator. Interview with the Facility Maintenance Manager at the time of observation acknowledged that they could not identify a remote annunciator. Ref: 1999 NFPA 99, Section 3-4.1.1.15 1999 NFPA 70, Article 700-12	K 147	the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. K 130 1. The Maintenance Director or Designee removed non-medical grade power taps from room #206 and #222 on or before 10/05/2016. 2. The Maintenance Director or Designee will complete an audit or Resident rooms to ensure non-medical grade power taps are not in use on or before 10/05/2016. 3. The Executive Director or Designee educated staff on or before 10/05/2016 regarding the inappropriate use or non-medical grade power taps. 4. The Maintenance Director or Designee will randomly audit resident rooms to ensure non-medical grade power taps are not in use (1) time per week for four (4) weeks then	10/05/2016

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K 147	Continued From page 9 from sinks that were not equipped with a ground-fault circuit-interrupters. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupters. 2. Observation on 09/06/2016 at 11:06 PM located at room 201 revealed a receptacle within approximately 2 feet from the sink without a ground-fault circuit-interrupter. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupter. Ref: 1999 NFPA 70, Article 210.8 3. Observation on 09/06/2016 at 1:45 PM revealed that the facility could not demonstrate they had a remote annunciator for their generator. Interview with the Facility Maintenance Manager at the time of observation acknowledged that they could not identify a remote annunciator. Ref: 1999 NFPA 99, Section 3-4.1.1.15 1999 NFPA 70, Article 700-12	K 147	weekly, until substantial compliance has been achieved. K 147 1. The Maintenance Director or Designee will ensure room #103, #104, #106, #114 and #201 are equipped with ground fault circuit interrupters on or before 01/23/2017. The Maintenance Director or designee will demonstrate that a remote annunciator for the generator exists on or before 01/23/2017. At this time we are requesting a time limited waiver through 01/23/2017. 2. The Maintenance Director or Designee will audit electrical outlets within 2 feet of a sink to ensure the outlet is equipped with ground fault circuit interrupters on or before 10/05/2016.	01/23/2017 Request for Time Limited waiver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536013	A. BUILDING 01 - MAIN BUILDING B. WING	09/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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