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

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APR 21 2017
Healthcare Licensing and Surveys

PRINTED: 04/03/2017
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
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/21/2017

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on March 20 & March 21, 2017. The facility was a fully sprinklered, single story building of Type V (111) construction with plan approval in 1987 and 2009. The building was equipped with a supervised, automatic wet sprinkler system with a dry sprinkler branch and an addressable fire alarm system. The facility had a capacity of 160 Medicare and Medicaid beds with a census of 143 residents.	K 000		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress to be free of obstructions to full use in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 03/20/2017 at 3:00 PM in the 300 corridor revealed a congested corridor with medical carts, patient lifts, and cleaning carts blocking access to exits. The means of egress must be continuously maintained free of obstructions to prevent potential injury or loss of life, and to allow full use in case of emergency. Interview with the Facility Maintenance Manager	K 211	K211 The means of egress s continuously maintained free of all obstructions to full use in case of emergency. A) The 300 corridor was cleared of lifts, cleaning carts and medical carts on 03/20/17. B) The maintenance director will randomly observe the facility corridors to ensure that corridors are continuously free of obstructions in case of emergency. 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.	5/6/17

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

Executive Director 4/14/17

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 CORRECTIONS VIA PHONE CALL WITH ADMINISTRATOR BRYAN MERRELL ON 5/01/17.

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K 211	Continued From page 1 at the time of observation revealed awareness of the requirement. REF: 2012 NFPA 101 Sections 19.2.1; 7.1.10.1; 4.5.3.2	K 211		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.	K 222	K222 Doors require a means of egress that shall not be equipped with a latch or a lock. A) North employee exit door's delayed egress locking system was repaired on 03/31/17. The 300 corridor door was repaired 03/23/17 and no longer requires an excess of 60 pounds of force to open. B) The maintenance director will randomly observe the facility egress doors to ensure locking systems are operable and require no more than 60 pounds of force to open. 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.	5/6/17

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K 222	Continued From page 2 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain delayed egress locking systems in accordance with 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 03/20/2017 at 3:44 PM at the north employee exit revealed that the delayed egress locking system was not operational. To exit the facility employees had to enter in a code at a keypad adjacent to the door. Failure of this system could delay egress of the facility in an emergency resulting in injury or loss of life.	K 222		

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K 222	Continued From page 3 Interview with the Facility Maintenance Manager at the time of observation revealed that the system had recently been repaired and they were not sure why the system was not working. REF: 2012 NFPA 101 Sections 19.2.2.4; 7.2.1.6.1 2. Observation on 3/20/2017 at 3:20 PM in the 300 corridor revealed that the northwest exit doors required in excess of 60 lbs to open. This could result in residents being unable to open the door in an emergency resulting in injury or loss of life. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the door required more than 60 lbs to open. REF: 2012 NFPA 101 Sections 19.2.2.4; 7.2.1.6.1.1.(3).(a)	K 222		
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by:	K 223	K223 Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position. A) The 300 corridor hazardous storage area door was repaired on 03/20/17 so it functions correctly. B) The maintenance director will randomly observe corridor doors to ensure they latch properly.	5/6/17

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K 223	Continued From page 4 Based on observation and staff interview, the facility failed to maintain self closing door devices in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. The findings were: Observation on 03/20/2017 at 3:15 PM in the 300 corridor revealed that a door to a hazardous storage area had a self closing device, but the door failed to latch properly. Failure of the door to latch could potentially result in fire spread and injury or loss of life. Interview with the Facility Maintenance Manager at the time of observation revealed awareness of the requirement. REF: 2012 NFPA 101 Sections 8.3.3.1; 19.3.2.1.3 2010 NFPA 80 Section 7.1.4.2	K 223	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.	
K 227 SS=D	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This STANDARD is not met as evidenced by: Base on observation and staff interview, the facility failed to provide a ramp in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 03/20/2017 at 2:30 PM at the	K 227	K227 Ramp, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge. A) Handrails will be added to the exterior ramp outside of the northwest corridor on or before 05/06/17. B) The maintenance director will randomly observe ramp to ensure handrails remain in place.	5/6/17

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K 227	Continued From page 5 exterior ramp outside of the northwest corridor revealed a rise equal to or greater than 14 inches and no handrails on either side of the ramp. Per the definition of the Life Safety Code a ramp is classified as a walkway with a slope greater than 1:20. During observation a length of approximately 150 inches and a height of approximately 14 inches was measured. The height exceeded the allowed 7.5 inches and therefore was classified a ramp. The absence of handrails could allow an individual to fall and cause injury. Interview with the Facility Maintenance Manager at the time of the observation revealed they were unaware of the requirement.	K 227	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.	
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting at transfer switch locations in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 110, Emergency and Standby Power. The findings were: Observation on 03/21/2017 at 1:00 PM in the emergency generator transfer switch room revealed no battery powered emergency lighting was provided. In an emergency where the transfer switch failed to operate the battery powered emergency lighting would provide illumination at the transfer switch to facilitate servicing a repair. Interview with the Facility Maintenance Manager at the time of observation	K 291	K291 Emergency lighting or at least 1-1/2-hour duration is provided automatically. A) Battery back-up powered emergency lighting in the emergency generator transfer switch room will be installed on or before 05/06/17. B) The maintenance director will randomly observe battery back-up powered emergency lighting to ensure proper functionality. 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.	5/6/17

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K 291	Continued From page 6 revealed they were not aware of the requirement. REF: 2010 NFPA 110 Section 7.3.1	K 291		
K 293 SS=E	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 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 maintain exit signage in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 03/20/2017 at 2:45 PM in the 400 corridor while facing north there was a missing exit sign that would inform residents to go either left or right to the exits. The lack of an exit sign at this location could delay residents egress during an emergency. Interview with the Facility Maintenance Manager at the time of observation revealed awareness of the requirement. REF: 2012 NFPA 101 Sections 19.2.10.1; 7.10	K 293	K293 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination. A) A directional exit sign will be installed on the 400 corridor on or before 05/06/17. B) The maintenance director will randomly observe corridor exit signs to ensure proper direction is provided to residents in case of an emergency. 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.	5/6/17
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the	K 321	K321 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating or an automatic fire extinguishing system.	5/6/17

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K 321	Continued From page 7 approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosure in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 3/20/2017 at 2:14 PM in the mechanical room outside the Arrowhead Dining room revealed numerous holes around the piping above the false ceiling that had not been fire caulked. The fire barrier needs to be maintained at all times and the ceiling penetrations would allow smoke and fire extension. Interview with the Facility Maintenance Manager at the time of observation revealed awareness of the	K 321	A) Ceiling penetrations in the mechanical room outside the Arrowhead Dining Room were fire caulked on 3/20/17. B) The maintenance director will randomly observe for ceiling penetrations to ensure all penetrations have been fire caulked. 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.	

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K 321	Continued From page 8 requirement, but was not sure why it had not been done. REF: 2012 NFPA 101 Sections 19.3.2.1; 8.7.1.1; 8.3.4	K 321		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electric utilities in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70, National Electrical Code. The findings were: 1. Observation on 03/21/2017 at 12:51 PM in the laundry room revealed unused openings for circuit breakers and switches in the electrical panel marked P2. These openings need to be closed to prevent injury to facility staff and residents. Interview with the Facility Maintenance Manager at the time of the observation acknowledged the openings. REF: 2012 NFPA 101 Sections 19.5.1.1; 9.1.2 2011 NFPA 70 Section 408-7	K 511	K511 Equipment using gas or related gas piping complies with NFPA 54. A) The unused openings for the circuit breakers and switches in the electrical panel marked P2 in the laundry room were properly enclosed with circuit breaker blanks on 03/27/17. The receptacle in the setup room for the Arrowhead Dining room near the sink was replaced with a GFCI outlet on 03/27/17. B) The maintenance director will randomly observe electrical panels to ensure there are no unused openings. The maintenance director will randomly observe receptacles near sinks to ensure a GFCI receptacle is in place	5/6/17

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K 511	Continued From page 9 2. Observation on 03/20/2017 at 2:05 PM in the setup room for the Arrowhead Dining room revealed the receptacle near the sink was not a ground fault circuit interrupter (GFCI) type. The GFCI needs to be used at this wet location to protect staff and residents from electrical shock. Interview with the Facility Maintenance Manager at the time of observation revealed they were not aware that the receptacle was not a GFCI. REF: 2012 NFPA 101 Sections 19.5.1.1; 9.1.2 2011 NFPA 70 Section 570-20	K 511	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.	
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741	K741 Smoking regulations shall be adopted and area shall be posted with signs that read NO SMOKING. A) No smoking signs were installed on main and therapy entrances on 03/20/17. Both signs include no smoking and the international symbol for not smoking. B) The maintenance director will randomly observe facility entrances to ensure NO SMOKING signs are posted as required. 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.	5/6/17

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 _____	03/21/2017

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 741	Continued From page 10 permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoking regulations in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 03/20/2017 at 1:20 PM at the main entrance revealed that the facility did not post a No Smoking sign despite being a no smoking facility. No Smoking signs need to be posted at all main entrances to the facility to insure residents safety. Further observation revealed that the facility did not provide secondary signs with the language that prohibits smoking or the international symbol for no smoking. Interview with the Facility Maintenance Manager at the time of observation revealed that during construction the signs were misplaced. REF: 2012 NFPA 101 Section 19.7.4	K 741		
K 930 SS=E	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain liquid oxygen equipment and storage facilities in accordance with the 2012 NFPA 101 Life Safety Code, and the 2012 NFPA 99, Health Care Facilities Code. The findings	K 930	K930 The storage and use of liquid oxygen in base reservoir containers and portable containers comply with NFPA 99. A) The 60 liter liquid oxygen tank was removed from resident's room on 3/20/17. B) The maintenance director will randomly observe resident rooms of residents who require high flow oxygen to ensure liquid oxygen tanks are not used.	5/6/17

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 _____	03/21/2017

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 930	Continued From page 11 were: Observation on 03/20/2017 at 2:50 PM in room 405 revealed a 60 liter liquid oxygen tank in a resident's room that did not provide fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. Large amounts of liquid oxygen in a non-rated area poses a severe fire risk to residents and staff. Interview with the Facility Maintenance Manager at the time of observation revealed they were not aware of the requirement. REF: 2012 NFPA 99 Section 11.7.4	K 930	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.	