STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on August 1, 2017. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, one story building of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet and anti-freeze sprinkler system with an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 92 residents.	K 000	Preparation or execution of this plan of correction does not constitute 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 the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance. **K 211** **Corrective Action** On 8/21/17 the Maintenance Director moved all the equipment stored in the corridor near the pink bathroom. Signs were put up to notify staff that no equipment is to be stored in this corridor on 8/23/17.	
K 211 SS=D	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 interviews, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/1/2017 at 11:18 AM in the corridor adjacent to the pink bathroom revealed	K 211	**Identification of Others** There are not other corridors used for storage of equipment that could be used for an exit in the facility. **Systemic Change** In-service education was provided to the facility staff on 8/31/17 by the SDC regarding not storing equipment in the corridor by the pink bathroom. A sign was placed at the entrance of the corridor stating no storage.	8/31/17

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

Brenda Hancock — NHA — 8/25/17

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.

RECEIVED
AUG 25 2017
Healthcare Licensing and Surveys

ACCEPTED POC VIA PHONE CALL WITH ADMINISTRATOR BRENDA HANCOCK ON 9-19-2017

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K 211	Continued From page 1 that the corridor was congested with a patient lift and a housekeeping cart blocking access to the exit. Further observation revealed 22 inches of clear width in the corridor. Failure to maintain means of egress as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Sections 19.2.1; 7.1.10.1; 4.5.3.2	K 211	The Maintenance Director/designee monitors the corridor by the pink bathroom for storage 5 days per week to ensure that nothing is stored in this area. Any negative findings are corrected immediately and addressed with staff. **Monitoring** The Maintenance Director reviews the results of his audit of the corridor with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue.	
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	K 222	**K 222** **Corrective Action** The south main exit delayed egress locking system was reset on 8/1/17 and the delayed egress locking system is functioning properly. The lock on the south main exterior exit door was plugged so that the lock can never be used as a locking mechanism on 8/23/17. **Identification of Others** All of the facility delayed egress doors were inspected by the Maintenance Director on 8/23/17 functioning properly. The Maintenance Director check all of the	8/31/17

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K 222	Continued From page 2 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. 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 the 2012 NFPA 101, Life Safety Code. The findings were:	K 222	facility exit doors on 8/16/17 for key locks and all have locks with functioning keys. **Systemic Change** In-service education was provided to the Maintenance Staff on 8/23/17 regarding the requirement of ensuring all delayed egress doors are functioning properly. In-service education was provided to the Maintenance staff on 8/23/17 regarding the requirement of having keys for all the exterior door locks. The Maintenance Director/designee checks all delayed egress doors monthly to ensure proper function. Maintenance Director/designee verifies the lock on the main door is plugged and the key is available for all other locks monthly. **Monitoring** The Maintenance Director reviews the results of his audit of the delayed egress doors and the exit door locks with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue.	

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K 222	Continued From page 3 Observation on 8/1/2017 at 9:14 AM at the south main exit revealed that the delayed egress locking system failed to operate when tested. To exit the facility, employees had to enter a code at a keypad adjacent to the door. Failure to maintain the system as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Sections 19.2.2.4; 7.2.1.6.1 Based on observation and staff interview, the facility failed to maintain egress doors in accordance with 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/1/2017 at 9:26 AM at the south main exit doors revealed that one of the doors had a key lock installed. When checked no key could be located for the lock. Failure to maintain egress doors as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated that the door was never locked, and he was not aware of any key for the lock. REF: 2012 NFPA 101 Section 19.2.2.2.4	K 222		
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	K 227	F 227 **Corrective Action** The facility has requested a Time Limited Waiver of 90 days to correct the ramp, and is consulting with a construction company regarding the best way to meet the requirement. **Identification of Others**	WAIVER 8/31/17

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K 227	Continued From page 4 This STANDARD is not met as evidenced by: Based 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: Observation on 8/1/2017 at 10:38 AM at the exterior ramp outside of the activities room revealed a rise equal to or greater than 28 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 231 inches and a height of approximately 28 inches was measured. The height exceeded the allowed 11.5 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 observation indicated he was not aware of the requirement. REF: 2012 NFPA 101 Sections 19.2.2.6; 3.3.219; 7.2.5.2 (2) (c)	K 227	There are no other ramps in the facility. **Systemic Change** In-service education was provided to the Maintenance staff on 8/23/17 related the requirement of ramps as an exit. The Maintenance Director checks the exit monthly to ensure that it remains a safe emergency exit. **Monitoring** The Maintenance Director reports any concerns related to the emergency exit with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue.	
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 interviews, the facility failed to maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety	K 291	**K 291** **Corrective Action** The Maintenance staff installed a new emergency lighting fixture with a 90 minute battery backup on 8/1817. **Identification of Others** The maintenance staff inspected all emergency lighting on 8/11/17 to ensure that all lights were functioning properly. No problems were identified.	8/31/17

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K 291	Continued From page 5 Code. The findings were: Observation on 8/1/2017 at 9:18 AM at the south main exit revealed that the emergency light failed to operate when tested. Failure to maintain emergency lighting as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Sections, 19.2.9.1; 7.9.2.1	K 291	**Systemic Change** The Maintenance Director/designee checks the emergency exit lighting monthly to ensure proper functioning. Any light identified as not functioning will be replaced. In-service education was provided to the maintenance staff by the NHA on 8/23/17 regarding the requirement of having all emergency lighting functioning at all times.	
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 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)	K 321	**Monitoring** The Maintenance Director reviews the results of the emergency lighting inspections with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue. **K 321** **Corrective Action** The activity office cleaned immediately on 8/22/17 by the Activity Director. A self closure was installed on the door of the activity office on 8/23/17 by the Maintenance Staff. **Identification of Others** The NHA checked all other offices	8/31/17

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K 321	Continued From page 6 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 enclosures in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/1/2017 at 10:49 AM in the Activities Director's office revealed a large amount of combustible material throughout the office. The combustibles need to be stored in a hazardous storage area with a fire barrier having a one-hour fire rating and a self closing door insuring the potential of fire spread is minimized. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Section 19.3.2	K 321	areas on 8/25/17 to ensure there were no other office areas with combustible materials throughout. There were none. **Systemic Change** Education was provided to the Activity Staff related to keeping the office area free of clutter and understanding the need for clear egress out of the office. The NHA checks the activity office weekly for clutter and safe egress. Any identified concerns are addressed with the activity staff for correction. **Monitoring** The results of the weekly monitoring of the activity office are reported to the Quality Assurance Performance Improvement Committee Monthly by the NHA for their review and resolution. These weekly audits for the activity office will continue for 3 months unless the Committee deems it prudent to continue.	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353	**K 353** **Corrective Action** The sprinkler gauges were replaced on 8/3/17. The escutcheon around the sprinkler head adjacent to room 155 was replaced on 8/7/17.	8/31/17

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K 353	Continued From page 7 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to perform sprinkler maintenance and testing in accordance with the 2012 NFPA 101, Life Safety Code, 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems and the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The findings were: 1. Observation on 8/1/2017 at 11:44 AM in the sprinkler room revealed that the sprinkler gauges had not been replaced or recalibrated within the last 5 years. The gauges were last tested in 1/2017. Failure to maintain sprinkler systems as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Sections 19.3.5.3; 9.7.5; 9.7.7; 9.7.8 2011 NFPA 25 Section 5.3.2 2. Observation on 8/1/2017 at 11:13 AM adjacent to room 155 revealed that the escutcheon around the sprinkler head was missing. Failure to maintain the sprinkler system as required could result in injury or death during an emergency.	K 353	The sprinkler water flow device was tested 8/3/17. **Identification of Others** There are no other sprinkler system gauges in the facility. The Maintenance Director checked all of the escutcheons around the sprinkler heads on 8/3/17. There are no other sprinkler water flow devices in the facility. **Systemic Change** In-service education was provided to the maintenance staff on 8/23/17 by the NHA related to the requirement of the sprinkler system gauges to be replaced every 5. The sprinkler gauges are recalibrated annually with the inspection. In-service education was provided to the Maintenance staff on 8/23/17 by the NHA regarding the requirement of escutcheon plates around every sprinkler head. The Maintenance Director/designee inspects the escutcheon plates monthly to ensure all are in place. In-service education was provided to	

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K 353	Continued From page 8 Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Section 19.3.5.3; 9.7.5 2010 NFPA 13 Section 6.2.7 Based on document review and staff interview, the facility failed to perform sprinkler maintenance and testing in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. The findings were: Document review on 8/1/2017 at 12:20 PM for the sprinkler water flow rest revealed that the facility could not establish that the sprinkler water flow devices had been tested during the inspection conducted on 7/20/2017. Failure to inspect and test sprinkler systems as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Sections 19.3.5.3; 9.7.5 2011 NFPA 25 Section 13.2.6.1	K 353	the Maintenance staff related to the requirement of having the sprinkler water flow device tested quarterly on 8/23/17 by the NHA. The Maintenance Director/designee checks the inspection date on the water flow device monthly to ensure the test is current. **Monitoring** The Maintenance Director reviews the results of his audit of the sprinkler gauges, escutcheon plates with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue.	
K 361 SS=D	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by:	K 361	**K 361** **Corrective Action** The combustible storage open to the corridor was removed on by the Medical Records Director **Identification of Others** There is no other open storage of combustible materials in the facility. **Systemic Change**	8/31/17

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K 361	Continued From page 9 Based on observation and staff interview, the facility failed to maintain areas open to corridors in accordance with 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/1/2017 at 12:15 PM adjacent to the laundry room revealed combustible storage open to the corridor. Failure to maintain areas open to corridors as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Section 19.3.6.1 (1) (a)	K 361	A locking medal cabinet was purchased on 8/16/17 by the Medical Records Director for all office supplies so they are no longer stored out in the open in the open corridor. The Medical Records Director checks the open storage in the corridor to ensure that no combustibles are out in the open 3 times per week and makes any corrections at the time it is identified. In-service education was provided to the Medical Records Director regarding the requirement of not storing combustibles in the storage open to the corridor on 8/23/17 by the NHA.	
K 922	NFPA 101 Gas Equipment - Other Gas Equipment - Other List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain gas equipment container storage in accordance with the 2012 NFPA 99, Health Care Facilities. The findings were: Observation on 8/1/2017 at 11:30 AM located in the oxygen storage room revealed 19 Liquid Oxygen containers that were 41 liters in capacity, and 13 oxygen containers of 25 liters. Further observation indicated that the facility had a total of 24,021 cubic feet of oxygen stored exceeding the allowable amount. Failure to maintain gas	K 922	**Monitoring** The Medical Records Director reviews the results of her audit of the open storage areas with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deems it prudent to continue. **K 922** **Corrective Action** The facility reduced the number of liquid oxygen containers to 15 and 6 small e-tanks on 8/30/17. **Identification of Others**	8/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2017

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) COMPLETION DATE
K 922	Continued From page 10 container storage as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 99 Sections 11.31; 11.3.2; 11.3.3; 11.3.4; 11.6.5	K 922	There is only 1 oxygen storage room in the facility. **Systemic Change** The Maintenance Director/designee checks the oxygen storage room 3 times per week to ensure that the facility does not exceed 16 liquid oxygen tanks. In-service education was provided to the Maintenance staff on 8/23/17 by the NHA regarding the requirement for oxygen storage. **Monitoring** The Maintenance Director reviews the results of his audit of the oxygen storage with the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This monitoring will continue for 3 months unless the QAPI Committee deemS it prudent to continue.	