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 _____	**10/03/2017**

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 A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 10/03/2017. 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, 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 146 certified Medicare and Medicaid beds with a census of 109 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 the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 10/3/2017 at 9:15 AM located at the northwest exit discharge revealed a set of	K 211	K211 1. The stair□s rise and slope for the northwest exit door to be repaired on or before 11/03/2017. 2. The Maintenance Director or designee will complete an audit on or	11/3/17

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

Electronically Signed | 10/27/2017

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.

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 _____	**10/03/2017**

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 211	Continued From page 1 stairs in which the last stair's rise was less than 4 inches and the tread had a slope greater than 1:48. Failure to maintain the means of egress as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of the observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Sections: 7.2.2.3.4; 7.2.2.2.1.1(a)	K 211	before 11/03/2017 of exit doors to ensure that the stair□s rise and slope maintain the means of egress. 3. The Maintenance Director or designee will complete a weekly audit for 30 days of exit doors to validate that the stairs and slope maintain the means of egress. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
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	K 222		10/27/17

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 _____	**10/03/2017**

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 222	Continued From page 2 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. 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:	K 222		

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 _____	**10/03/2017**

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 222	Continued From page 3 Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 10/3/2017 at 8:50 AM at the north doors to the courtyard across from the PT area revealed that one of the doors had a key lock installed. Further observation revealed that the south exit doors in the 100 corridor also had a key lock installed. When checked no key could be located for the locks. Failure to maintain exit 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 unaware of any key for the lock. REF: 2012 NFPA 101 Section: 19.2.2.2.4 2. Observation on 10/3/2017 at 9:40 AM in the central courtyard revealed that the north gate required in excess of 15 lbs of force to open. This could result in residents being unable to open the door in an emergency resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Sections 19.2.2.2; 7.2.1.4.5.1	K 222	K222 1. The key lock for the north door to the courtyard across form the PT area and the exit door in the 100 corridor was removed on 10/03/2017. The central courtyard north gate was repaired on 10/04/2017 and requires less than 15 lbs of force to open. 2. The Maintenance Director or Designee will audit exit doors on or before 10/27/2017 to validate key locks are removed and doors require less than 15 lbs of force to open. 3. The Maintenance Director or Designee will complete a random weekly audit for 30 days of exit doors to validate keys locks are removed and doors require less than 15 lbs of force to open. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 227 SS=E	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.	K 227		3/2/18

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 _____	10/03/2017

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 227	Continued From page 4 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: Based on observation and staff interview, the facility failed to maintain ramps in accordance with the 2012 NFPA 101, Life Safety Code. the findings were: 1. Observation on 10/3/2017 at 11:00 AM located outside the south exit stairwell exit door to the public way revealed a ramp that had a rise approximately 10 inches and a run of approximately 72 inches. Further observation revealed the bottom landing to be approximately 10 inches and no handrails were provided for the ramp. Failure to maintain ramps 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, and the facility was in the process of replacing the ramp. REF: 2012 NFPA 101 Sections: 19.2.1; 7.2.5 2. Observation on 10/3/2017 at 11:00 AM located outside the dining room east exit doors revealed a ramp that had been cited as deficient in the previous survey, which has not been corrected in accordance with the Life Safety Code. Contractors were on-site and removing the ramp in preparation for the installation of a compliant ramp at the time of the survey. Failure to maintain ramps as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation	K 227	K227 1. At this time we are requesting a time limited waiver through 03/02/2018 to allow time to repair the south exit stairwell exit door to the public way ramp and handrails as well as the ramp outside of the dining room east doors. 2. The Maintenance Director or designee will complete an audit of exit door ramps to the public way on or before 10/27/2017 to validate an appropriate egress. 3. The Maintenance Director or designee will complete a random weekly audit for 30 days of exit door ramps to the public way to validate an appropriate egress. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. At this time we are requesting a time limited waiver through 03/02/2018. Letter of request was sent to HLS office via email.	

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 _____	**10/03/2017**

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 227	Continued From page 5 indicated he was aware of the requirement, and stated that there was a delay in receiving plan approval from the City Building Department, which has prolonged the installation of a compliant ramp. REF: 2012 NFPA 101 Sections: 19.2.1; 7.2.5	K 227		
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 maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 10/3/2017 at 8:57 AM in the PT room revealed that the emergency lights 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	K291 1. The emergency lights in the Rehab Gym were repaired on or before 10/27/2017. 2. The Maintenance Director or designee will complete an audit of emergency lights to validate they are in good repair on or before 10/27/2017. 3. The Maintenance Director or designee will complete a weekly audit for 30 days of emergency lights to validate they are in good repair. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	10/27/17
K 293 SS=D	NFPA 101 Exit Signage	K 293		10/27/17

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 _____	**10/03/2017**

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 293	Continued From page 6 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 signs in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 10/3/2017 at 9:40 AM in the central courtyard revealed that the only means of egress from the courtyard had a "Not an Exit" sign attached to the gate. During an emergency this could cause confusion and delay evacuation from the facility resulting in injury or death. 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; 7.10.1.3	K 293	K293 1. The Not an Exit sign was removed on 10/03/2017. 2. The Maintenance Director or designee will complete an audit of emergency exits to validate appropriate signage is in place on or before 10/27/2017. 3. The Maintenance Director or designee will complete a weekly audit for 30 days of emergency exits to validate appropriate signage is in place. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		10/27/17

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 _____	**10/03/2017**

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 363	Continued From page 7 hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain corridor doors 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: Document review and staff interview on	K 363	K363 1. The Maintenance Director completed the annual fire door assembly inspection on 10/16/2017. 2. The Executive Director or designee reviewed with the Maintenance Director to validate that the annual fire door corridors	

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 _____	**10/03/2017**

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 363	Continued From page 8 10/3/2017 at 2:40 PM revealed the facility could not verify that the required annual fire door assembly inspection had been completed. Failure to maintain fire door assemblies 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: 8.3.3.1 2010 NFPA 80 Section: 5.2.1	K 363	assembly inspection is completed annually on 10/16/2017. 3. The Executive Director or designee reviewed with the Maintenance Director to validate that the annual fire door corridors assembly inspection is completed annually. 4. The Maintenance Director or designee will report the tracking and trending of the review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 791 SS=D	NFPA 101 Construction, Repair, and Improvement Operati Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 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 during construction in accordance with the 2012 NFPA 101, Life Safety Code, and the 2009 NFPA 241, standard for safe guarding Construction Alteration, and Demolition Operations. The findings were: Observation on 10/3/2017 at 9:15 AM located at	K 791	K791 1. The Maintenance Director or designee temporarily repaired the northwest exit sidewalk on 10/03/2017 and the permanent repair was on 10/04/2017. 2. The Maintenance Director or designee will audit emergency exit	10/27/17

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 _____	10/03/2017

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 791	Continued From page 9 the northwest exit discharge revealed a sidewalk that had been removed during construction. Further observation revealed that this sidewalk was the only means of egress to the public way from the designated exit. 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 unaware of the requirement. REF: 2012 NFPA 101 Sections: 18.7.9; 4.6.10; 7.1.10.1	K 791	sidewalks on or before 10/27/2017 to validate the means of egress is maintained. 3. The Maintenance Director or designee will audit emergency exit sidewalks weekly for 60 days to validate the means of egress is maintained. 4. The Maintenance Director or designee will report the tracking and trending of the review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 911 SS=D	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, the 2011 NFPA 70, National Electrical Code, and the 2012 NFPA 99, Health Care Facilities. The findings were: 1. Observation on 10/3/2017 at 9:09 AM in Central Storage revealed items stored within 9 inches of the front of the electric panelboard. Failure to maintain the required clearance around	K 911	K911 1. Items within 9 inches of the front of the electrical panel board in the Central Storage were removed on 10/05/2017. Openings on the electrical panel on the third floor were repaired on or before 10/27/2017. Room 109B bed control was repaired on or before 10/27/2017. 2. The Maintenance Director or	10/27/17

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 _____	**10/03/2017**

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 911	Continued From page 10 an electric panelboard could result in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101 Section: 9.1.2 2011 NFPA 70 Section: 110-26; 384-8 2. Observation on 10/3/2017 at 12:22 PM in the third floor pantry revealed that the electrical panel had several unused and unprotected openings. Failure to maintain electrical panels as required could cause a shock hazard to staff and residents resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. 3. Observation on 10/3/2017 at 9:32 AM in room 109B revealed that the bed control unit had exposed wires. Further observation revealed that the bed control unit was plugged directly into the wall. Failure to maintain power cords as required could result in resident injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement, but was not aware of that particular unit. REF: 2012 NFPA 99 Section: 10.4.2.2 REF: 2012 NFPA 101 Section: 9.1.2 2011 NFPA 70 Section: 110-12	K 911	designee will audit electrical panel boards on or before 10/27/2017 to validate items are not within 9 inches of the front of the panelboard and that there are no unprotected openings. The Maintenance Director or designee will audit bed controls units on or before 10/27/2017 to validate they are in good repair. 3. The Maintenance Director or designee will complete a weekly audit for 30 days to validate items are not within 9 inches of the front of the panel board and that there are no unprotected openings. The Maintenance Director or designee will audit bed controls units weekly for 30 days to validate they are in good repair. 4. The Maintenance Director or designee will report the tracking and trending results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	