STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 B. WING _____	01/31/2019

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 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 31, 2019. 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 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single-story building with a basement of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet and anti-freeze sprinkler systems, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 94 residents.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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	K 222		2/23/19

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

Electronically Signed | 02/22/2019

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K 222	Continued From page 1 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. 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	K 222		

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K 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected 1 of 9 facility exits. The findings were: Observation on 1/31/2019 at 11:37 AM at the facility exit adjacent to room 147 revealed the delayed egress locking system failed to operate as designed. When tested the release process failed to activate an audible signal in the vicinity of the door as required. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1 (3)(c) .	K 222	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 222 Egress doors CORRECTIVE ACTION The delayed egress locking system on the facility exit door adjacent to room 147 was repaired on 2/19/19 and audible signal functions appropriately. IDENTIFICATION OF OTHERS The Maintenance Director/designee checked delayed egress locking systems on the exit doors to ensure that they each audible signal functions properly on 2/18/19. All are functioning correctly. SYSTEMIC CHANGE	

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K 222	Continued From page 3	K 222	In-service education was provided to the Maintenance staff on 2/15/19 by the NHA regarding the requirement of all delayed egress locking systems on the facility exit doors have audible signals that function appropriately. The Maintenance Director/designee checks all delayed egress locking systems on exit doors to ensure that the audible signal functions properly 1 time per month. Any identified concerns related to the delayed egress locking systems audible signal on the exit door are immediately corrected. MONITORING The Maintenance Director reports any identified patterns or trends regarding the audible signals of the delayed egress locking systems on the exit doors to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be	K 321		2/23/19

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K 321	Continued From page 4 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, 19.3.5.9 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 REQUIREMENT 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. Failure to maintain hazardous areas as required could result in injury or death during an emergency. The deficiency affected 1 of numerous rooms in the facility. The findings were: Observation on 1/31/2019 at 10:45 AM adjacent to room 117 revealed a storage room greater than 50 square feet filled with combustible material. Further observation revealed the self-closing door failed to latch when tested.	K 321	K 321 Hazardous Areas-Enclosures CORRECTIVE ACTION The latch on the storage door adjacent to room 117 was repaired by the maintenance staff on 1/31/19. IDENTIFICATION OF OTHERS The Maintenance Director/designee checked all of the storage room doors to ensure that they latch properly on 2/18/19.	

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K 321	Continued From page 5 Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 .	K 321	All are functioning correctly. SYSTEMIC CHANGE In-service education was provided to the Maintenance staff on 2/15/19 by the NHA regarding the requirement of all storage room doors to latch properly at all times. The Maintenance Director/designee checks all storage room doors to ensure that they latch properly 1 time per month. Any identified concerns related to the door not latching properly are immediately corrected. MONITORING The Maintenance Director reports any identified patterns or trends regarding the latching of storage room doors to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 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	K 741		2/23/19

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K 741	Continued From page 6 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 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoking areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoking areas as required could cause a fire resulting in injury or death. The deficiency affected 1 of 2 smoking areas (Resident and Staff). The findings were: Observation on 1/31/2019 at 10:25 AM at the resident's smoking area revealed numerous cigarette butts discarded on the ground. Further observation revealed the cigarette butts mixed in with combustible yard waste. Interview with the facility maintenance staff at the time of observation acknowledged the cigarette butts on the ground, and indicated awareness of the requirement.	K 741	K 741 Smoking Regulations CORRECTIVE ACTION The Maintenance staff swept up the cigarette butts around the facility on 1/31/19. IDENTIFICATION OF OTHERS All residents have the potential to be affected by cigarette butts on the ground around the facility. SYSTEMIC CHANGE	

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K 741	Continued From page 7 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.7.4	K 741	Education was provided to the Maintenance staff regarding cleaning up the cigarette butts around the outside of the facility on 2/15/19 by the NHA. Staff education was completed by the SDC on 2/23/19 regarding ensuring that the residents place cigarette butt in the proper receptacle during smoke break and that staff who smoke dispose of their cigarette butts properly in the available receptacles. A meeting was held with the residents who smoke to discuss the requirement of disposing of their cigarette butts in the proper receptacles by the NHA on 2/11/19. The Maintenance Director/designee conducts rounds around the facility 5 days per week to ensure that the cigarette butts are not left lying around on the ground outside of the facility. MONITORING The Maintenance Director reports any identified patterns or trends regarding cigarette butts being left on the ground to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on January 31, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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

Electronically Signed | 02/14/2019

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.