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 _____	02/22/2011

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 ~~Requirements for Long Term Care Facilities~~ Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (000) construction with plan approval in 1961. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze zone and with a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 90 residents.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K 18 1. Door to the MDS office was fixed with fire resistant weather stripping and no gap exists. 2. All doors protecting corridor openings were checked. 25 other seals were found and were replaced on or before 4/7/2011. 3. All corridor doors to be audit weekly to ensure there are no gaps per our Plan Maintenance Program (TELS). - Results from the TELS program will be brought to safety meeting	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume | TITLE: NHA | (X6) DATE: March 19 2011

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
Wyoming Dept of Health

FOR ACCEPTED W/ JENNIFER REAUME, NHA, ON 3/25/11.

MAR 21 2011

Office of Healthcare Licensing and Surveys

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Wyoming Dept of Health

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K 018	Continued From page 1	K 018		
K 050 SS=E	This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation of the minimum data set (MDS) office on 2/22/11 at 1:19 PM showed the top of the corridor door was below the bottom of the door stop. The gap between the top of the door and the door frame was 1/4-inch. At the time of observation the maintenance director reported all corridor doors were inspected on a weekly basis. He stated he did not know why the door had not been noticed and repaired. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff members were familiar with emergency procedures during a fire drill on 1 of 3 shifts. The findings were: Observation of the fire drill on 2/22/11 at 2:17 PM	K 050	4. Results from the TELS program will be brought monthly to QA&A meeting for 3 months and the QA&A committee will track and trend results to determine if further review and recommendations for continued monitoring based on Compliance. Compliance date 4/7/2011 K 50 Corrective Action: Fire drill performed with staff responding appropriately. 2. All future fire drills. 3. 1:1 education with the C.N.A who was the first responder. 1:1 with the nurse. SDC/designee will educate	

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K 050	Continued From page 2 showed that after entering the room with the simulated fire the first responder closed the corridor door, but did not call out "Code Red" as defined in the facility fire policy. The responder walked past two fire alarm pull stations and went to the nurses' station and announced the "Code Red" through the intercom system. The fire alarm system was activated by another staff member after hearing the announcement more than 1 minute and 30 seconds after the "fire" was found. Furthermore, a medication cart was left in the corridor in the smoke compartment of fire origin throughout the entire drill. The nurse in the immediate area reported she was not aware the corridors were required to be cleared during the activation of the fire alarm system. After the drill, the first responder reported she was not aware that she needed to call out "Code Red" and immediately activate the fire alarm pull station. She also reported that she had been employed at this facility for one month.	K 050	New staff on proper procedures for fire drill. -Maintenance Director /designee will review with staff the results of future conducted fire drills. Results from the yearly fire drills will be brought to QA&A meeting for review for 3 months and then reassess the need for continued monitoring based on compliance. Compliance Date: 4/7/2011	