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 _____	08/14/2019

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 14, 2019. 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, Exisiting 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 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 85 residents.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain emergency lighting as required could result in injury or death during an emergency. The deficiency affected 1 of 2 testing	K 291	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	9/7/19

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

Electronically Signed | 09/06/2019

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	535025	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/14/2019**

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K 291	Continued From page 1 requirement for emergency lighting. The findings were: Document review on 8/14/2019 at 2:15 PM revealed the facility could not verify that the annual 90 minute functional test had been conducted on the battery powered emergency lighting. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.9.1; 7.9.3.1.1(3)	K 291	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 291 Emergency Lighting CORRECTIVE ACTION The Maintenance Director conducted a 90 minute emergency lighting test on 8/21/19 and documented the test. IDENTIFICATION OF OTHERS All areas with emergency lighting are affected by this testing. SYSTEMIC CHANGE The Maintenance staff was provided in-service training by the NHA on 8/22/19 related to the required 90 minute annual lighting test, and documentation of the test. The Maintenance Director/designee tests all emergency lighting annually for 90 minutes and documents this test. MONITORING The Maintenance Director reports any identified patterns or trends related to the 90 minute emergency lighting test to the Quality Assurance Performance Improvement Committee monthly or their	

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K 291	Continued From page 2	K 291	review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain combustible decoration in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain combustible decorations as required could contribute to fire spread resulting in injury or death. The deficiency affected two (2) of numerous rooms. The findings were: Observation on 8/14/2019 at 10:20 AM in room 147 revealed combustible decorations covering more than 50 percent of a resident's sleeping	K 753	K 753 Combustible Decorations CORRECTIVE ACTION The combustible decorations on the walls in rooms 147 and 135 were reduced to less than 50% on 9/5/19. IDENTIFICATION OF OTHERS	9/7/19

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K 753	Continued From page 3 room wall. Further observation in room 135 also revealed combustible decorations covering more than 50 percent of a wall. Interview with the facility maintenance supervisor 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: 19.7.5.6(d) .	K 753	The Maintenance Director audited all other resident rooms in the facility to identify any other rooms that may have combustible decorations covering more the 50% of the wall on 9/2/19. The issue was corrected in any other identified rooms. SYSTEMIC CHANGE The Maintenance staff was provided in-service training related to the requirement of having less than 50% of the wall covered by combustible decorations on 8/22/19 by the NHA. The Maintenance Director/designee conducts monthly rounds to identify any resident room that that has a wall more than 50% covered with combustible decorations. Corrections are made to any room identified as having more than 50% of the room covered. MONITORING The Maintenance Director reports any identified patterns or trends regarding greater than 50% combustible decorations covering the walls 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 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		9/7/19

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K 923	Continued From page 4 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 5 Based on observation and staff interview, the facility failed to store oxygen tanks in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 99, Health Care Facilities Code. Failure to store oxygen tanks as required could result in injury or death during an emergency. The deficiency affected 1 of 7 storage rooms in the facility. The findings were: Observation on 8/14/2019 at 11:12 AM in the oxygen storage room revealed oxygen concentrators, which contain combustible materials, stored in the room. Only gas cylinders, reusable shipping containers, and their accessories shall be permitted to be stored in rooms containing gas cylinders. Further observation revealed the oxygen concentrators stored within 5 feet of the gas cylinders. Interview with the facility maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was unaware that oxygen concentrators could not be stored in the oxygen room. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2.4 2012 NFPA 99, Section: 5.1.3.2.3; 11.3.2.3(2)	K 923	K 923 Gas Equipment CORRECTIVE ACTION The Oxygen concentrators were moved to a separate location by the Maintenance Director on 8/22/19. IDENTIFICATION OF OTHERS There is only one oxygen storage room in the facility. SYSTEMIC CHANGE The Maintenance Staff was provided in-service training related to not storing the oxygen concentrators in the Oxygen storage room on by the NHA. The Maintenance Director/designee checks the oxygen storage room weekly to ensure that no oxygen concentrators are stored in the oxygen storage room. A sign was placed on the outside of the oxygen storage room indicating that no concentrators are to be stored in the oxygen storage room. MONITORING The Maintenance Director reports any identified patterns or trends oxygen concentrators being stored in the oxygen storage room to the Quality Assurance Performance Improvement Committee	

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K 923	Continued From page 6	K 923	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 August 14, 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

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.