DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING 01 B. WING ______	01/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 (111) construction with plan approval in 1987. The building was equipped with a supervised automatic wet sprinkler system and a dry sprinkler branch with an addressable fire alarm system. The facility had a capacity of 160 certified Medicare and Medicaid beds with a census of 148 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 018 The facility will ensure resident room corridor doors have no impediment to the closing of the doors. This will be accomplished by: A) The door and latch were adjusted during the survey to ensure that resident room door #316 securely closes. B) The maintenance staff will quarterly observe corridor room doors and if a door fails to securely close maintenance will immediately adjust door and latch to ensure the door closes securely.	01/04/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 1/28/11

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.

PoC w/ Brian [illegible], E.D., [illegible]

RECEIVED
Wyoming Dept of Health
JAN 28 2011
Office of Healthcare Licensing and Surveys

[illegible]

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K 018	Continued From page 1 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 on 1/04/11 at 10:44 AM showed the corridor door to resident room #316 was not smoke resistant. The door's latch bolt was did not insert into the strike plate, with three attempts. At the time of observation the maintenance director reported the corridor doors were inspected quarterly to ensure they were smoke resistant. He stated he had not known this door did not securely latch into its frame.	K 018	C) The maintenance staff will report quarterly at the QI meeting the findings of their observations. This will happen for one quarter or until compliance is achieved.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 6 smoke barrier walls were smoke resistant. The findings were:	K 025	K 025 The facility will ensure smoke barrier walls are free from unsealed penetrations. A) The smoke barriers wall in rehabilitation gymnasium was patched with sheet rock and was also fire caulked. B) The maintenance staff will inspect smoke barriers and repair if necessary semi-annually. C) The maintenance staff will report quarterly at the QI meeting the findings of their observations. This will happen for one quarter or until compliance is achieved.	01/23/11

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K 025	Continued From page 2 Observation of the smoke barriers on 1/04/11 at 2:20 PM showed the smoke barrier wall between resident room #413 and the rehabilitation gymnasium was not smoke resistant. The wall had a 4 inch square unsealed computer cable penetration. At the time of observation the maintenance director reported he was aware smoke barrier were required to be smoke resistant. Furthermore, he reported smoke barrier walls were inspected semi-annually; However, he did not know why the hole had not been sealed after the computer cable was installed.	K 025		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 8 of 9 exit doors were provided with delayed egress unlocking instructions. The findings were: Observation of the 200 hall exit door on 1/04/11 at 9:46 AM showed the door was equipped with a delayed egress magnet locking system and key pad. Further review showed the door was not provided with a sign reading "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS." At the time of observation the maintenance director reported 8 of 9 exits were equipped with delayed egress locks, and none of them were provided with the required signs. Furthermore, he reported the magnetic locks	K 038	K 038 Exit access is arranged so that exits are readily accessible at all times. A) Signs posted on all exit doors that read, "PUSH UNTIL ALARM SOUNDS. CAN BE OPENED IN 15 SECONDS." B) The maintenance staff will randomly observe exit doors and replace signs as needed. C) The maintenance staff will report quarterly at the QI meeting the findings of their observations. This will happen for one quarter or until compliance is achieved.	01/11/11

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K 038	Continued From page 3 would release with the activation of the fire alarm system and loss of facility power. The magnetic locks were noted to release with the activation of the fire alarm system during the drill at 3:31 PM. The release combination was posted on the top of the door frame at each exit. No other signage was evident for any of the exits.	K 038		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure temporary wiring did not replace permanent fixed wiring, failed to replace damaged electrical equipment, and failed to ensure outlets in wet locations had ground faculty circuit interruption (GFCI) protection in 4 of 6 smoke compartment. The findings were: 1. Observation of the electrical system on 1/04/11 between 9:30 AM and 10:30 AM showed the lamp in resident room #206 was plugged into two extension cords, in-line. The television set in resident room #218 was plugged into a 3-way adapter. At the time of the observation the maintenance director reported he was aware the aforementioned electrical adapters were prohibited. Furthermore, he reported the electrical system was inspected quarterly. 2. Observation of the electrical system on 1/04/11 at 9:25 AM showed the electrical cord for the oxygen concentrator in resident room #115 was damaged at the plug. Further review showed the inner wires were exposed and bent at a 90	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70: A) Maintenance removed extension cords from room #206 during survey. Educated both staff and family members on use of extension cords. Maintenance removed a 3-way electrical adapter from room #218 during the survey and replaced with an UL approved surge protector. Education provided to resident, staff, and family on electrical safety. Maintenance staff replaced concentrator in room #115 with damage at the plug with a new concentrator during the survey. Maintenance removed ground blade from outlet in room #219 during the survey and educated staff to inspect and notify maintenance of any damaged electrical cords or outlets. Maintenance replaced outlets in 200 hall medication room on 01/23/2011 with GFCI protected outlets that were within 6 feet of the sink.	01/23/11

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K 147	Continued From page 4 degree angle. 3. Observation of the electrical system on 1/04/11 at 10:06 AM showed the electrical outlet near bed "A" in resident room #219 had a ground blade broke off in the outlet's ground port. At the time of the observation the maintenance director reported housekeeping staff was instructed to report any damaged electrical equipment. 4. Observation of the electrical system on 1/04/11 at 10:20 AM showed the electrical outlet in the 200 hall medication room was located within 6 feet of a sink. Observation showed the outlet was actually located only 18 inches from the sink and lacked GFCI protection. At the time of the observation the maintenance director reported he was aware of the aforementioned requirement, but could not explain why the outlet had not been replaced.	K 147	B) The maintenance staff will audit all electrical wiring, cords, and outlets monthly to ensure wiring, cords, and outlets are safe and in working order. C) The maintenance staff will report ~~quarterly at the QI meeting any~~ problems with the lock. This will happen for one quarter or until compliance is achieved.	