CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING 01 - CHEYENNE HEALTH CARE B. WING _____	01/25/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE	2700 EAST 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 This Life Safety Code (LSC) survey was conducted on 01/25/2005. The existing section of the 2000 edition of the (LSC) was used in keeping with the requirements of the Federal Register at 42CFR 483. 70 (a). This facility was constructed in 1963 of Type V (111) construction. It is single story and equipped with a partial sprinkler system due to sprinklers missing under the overhangs and in the walk in cooler. The deficiencies noted were as follows:	K 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide smoke barrier doors at 3 of 6 locations that would resist the passage of smoke. The findings included: 1. At approximately 10:30 AM, it was observed	K 027	K-027: The Maintenance Director will ensure that all smoke barrier doors will close to form a smoke resisting closure. The Maintenance Director will conduct random testing of the smoke barrier doors. Testing will be conducted two (2) times per week for three (3) weeks then monthly inspections ongoing. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance. Date of compliance is February 28, 2005.	

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

Administrator 02/11/05

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.

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CHEYENNE HEALTH CARE	2700 EAST 12TH STREET CHEYENNE, WY 82001

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K 027	Continued From page 1 that the South West, North West and North East smoke barrier doors of the building were not closing to form a smoke resisting closure. This was verified with maintenance personnel at that time	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated, protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide hazardous areas with fire separation. The findings included: 1. At approximately 10:15 AM, it was observed that the activity office had an accumulation of newspapers and magazines. 2 At approximately 11:00 AM, it was observed that the north dining room contained 10 boxes of paper back books under the wood cabinets. 3. At approximately 11:30 AM, it was observed that a small oxygen tank, newspapers,	K 029	K-029: The Activity Director and the Director of Nurses will ensure that their offices are free of excessive combustibles and clutter. The Activities Director will remove the boxes containing paperback books located in the north dining room. The Administrator will conduct random reviews of the condition of the Activity Director's and Director of Nurse's offices. These reviews will be two (2) times per week for three (3) weeks. The Administrator will conduct random reviews of the north dining room to ensure that no boxes or other combustibles are stored on the floor. These reviews will be two (2) times per week for three (3) weeks and then monthly ongoing. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance. Date of compliance is February 28, 2005.	

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K 029	Continued From page 2 magazines and three cardboard boxes full of combustibles was observed to be scattered across the the floor of the Director of Nurses Office (DON). This was verified with the maintenance director at this time.	K 029	K-046: The Maintenance Director will ensure that emergency power is available to all lights located outside the exits of the facility. The Maintenance Director will contact the appropriate vendor(s) to acquire bids and applicable construction plans in accordance with State licensure rules and regulations.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1¼ hour duration is provided in accordance with 7.8. 19.2.9.1. This Standard is not met as evidenced by: Based on observation and staff interview during the survey on 1/25/2005, the facility failed to provide emergency power for the lights located outside the exits of the facility. 1. It could not be confirmed by observation or facility staff interview that the lights on the exterior of 9 of 9 exits were provided with emergency power. This was discussed during the exit interview with the administrator and maintenance director.	K 046	The Maintenance Director will ensure that the installation of the emergency power is pre-approved by the State Survey Agency prior to construction. The Maintenance Director will ensure that the vendor(s) complete the construction in accordance with the State Survey Agency approved construction plans. Upon completion, the Maintenance Director and the vendor(s) will conduct the appropriate testing of the emergency power to ensure operational capacity in accordance with State licensure rules and regulations. The Maintenance Director will ensure that the monitoring and maintenance of the emergency power are incorporated into the facility's preventive maintenance schedule. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance. Date of compliance is February 28, 2005.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection,	K 056		

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CHEYENNE HEALTH CARE	2700 EAST 12TH STREET CHEYENNE, WY 82001

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K 056	Continued From page 3 Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based upon observation and staff interview it was determined during the survey that the facility failed to provide a complete sprinkler system. The findings included: 1. It was observed at 1:00 PM, on 1/25/2005, that the walk in cooler located in the kitchen did not have a sprinkler head installed. 2. During the tour of the building on the day of the survey it was observed that sprinkler heads were not installed in exterior awnings/canopies which exceeded 4 feet in depth. Examples of these situations were located at the southwest hallway exit, north entrance, and the canopy on the south side of the south east wing. Also 4 of 4 canopies partially covering their individual courtyards were not sprinklered.	K 056	K-056: The Maintenance Director will ensure that a sprinkler system will be installed in the walk-in cooler located in the kitchen and all exterior awnings/canopies that exceed four (4) feet in depth. The Maintenance Director will contact the appropriate vendor(s) to acquire bids and applicable construction plans in accordance with State licensure rules and regulations. The Maintenance Director will ensure that the modification to the existing sprinkler system is pre-approved by the State Survey Agency prior to construction. The Maintenance Director will ensure that the vendor(s) complete the construction in accordance with the State Survey Agency approved construction plans. Upon completion, the Maintenance Director and the vendor(s) will conduct the appropriate testing of the sprinkler system to ensure operational capacity in accordance with State licensure rules and regulations. The Maintenance Director will ensure that the modified sections of the sprinkler system are incorporated into the facility's preventive maintenance schedule. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance. Date of compliance is February 28, 2005.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by:	K 130		

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	536025	A. BUILDING 01 - CHEYENNE HEALTH CARE B. WING _____	01/26/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE	2700 EAST 12TH STREET CHEYENNE, WY 82001

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K 130	Continued From page 4 DUE TO COMPUTER PROGRAM PROBLEMS K 108 (Emergency Lighting,) IS BEING REPORTED AT K130. Based upon observation and staff interview during the survey, it was determined that the facility failed to provide emergency lighting at the sight of the generator. This was verified with maintenance staff and administration at the time of the exit interview.	K 130	K-130: The Maintenance Director will replace the battery in the light located near the emergency generator. The Maintenance Director will monitor the effectiveness of the emergency lighting and incorporate the practice as part of the facility's preventive maintenance schedule. Results will be reviewed monthly at the QA&A committee for trends. Recommendations will be followed to ensure continued compliance. Date of compliance is February 28, 2005.	

TOTAL P.10

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