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 _____	**03/01/2023**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 03/01/2023. Based upon the findings, it was determined the facility was in compliance with the requirements of 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/01/2023. Requirements for Long Term Care Facilities Section 42 CFR 483.90 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 one story building of Type V (111) construction with plan approval in 1987 and 2009. The building was equipped with a supervised wet sprinkler system with a dry sprinkler branch, and an addressable fire alarm system. The facility had 160 certified Medicare and Medicaid beds with a census of 107 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		3/31/23

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

Electronically Signed | 03/24/2023

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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K 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a level means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a level means of egress as required could lead to falls during egress, which may result in injury or death. The deficiency could impact all staff, residents and visitors utilizing the identified means of egress. The findings were: Observation on 03/01/2023 at 8:45 AM at the exit doors on the south 200 hall found that a crack had formed in the concrete walkway due to soil expansion, which had resulted a sidewalk height difference of approximately 1/2" at the crack. Additional observation at 10:00 AM found that at the concrete walkway by the exit for west 300 hall had experienced a similar condition with a height difference in the walking surface of approximately 1" at the crack. Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sections 19.2.1, 7.1.6.2	K 211	To be completed before 03/31/2023 by an outside concrete finisher. Concrete walks outside the 200 hall exit and the 300 hall exit doors will be ground to level and cracks filled to ensure a level walking surface. Will be monitored and maintained by maintenance staff throughout the year.	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the	K 223		3/1/23

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K 223	Continued From page 2 closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching and self-closing door as required could result in fire or smoke propagation during an emergency, which may delay or prevent egress during an emergency. The deficiency could impact all staff, residents, and visitors in the affected areas. The findings were: Observation on 03/01/2023 at 11:02 AM at the physician's office revealed that the door was equipped with a self-closing device, but that a door wedge had been placed under the door, rendering it incapable of closing during an emergency. Additional observation on 03/01/2023 at 12:20 PM at the kitchen storage doors revealed that the door was equipped with a self-closing device, but a crate was placed in front of the door, which prevented it from closing. Additional observation on 03/01/2023 at 12:35 PM at the private dining door revealed that the door failed to latch when dropped with no initial motion.	K 223	03/01/2023 @ 3:00 pm: The wedge holding the back physicians door was removed. Staff and physicians were instructed on the deficiency and will monitor daily as to keep in compliance. 03/01/2023 @ 12:20 pm: The crate that was used to prop the kitchen storage door open was removed. Staff and Dietary Manager was educated on the deficiency and will monitor on a daily basis to ensure compliance. 03/01/2023 @ 12:45 pm: Maintenance staff adjusted the door closer on the private dining room door to ensure proper closing. This will be monitored weekly by maintenance staff and annotated in T.E.L.S.	

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K 223	Continued From page 3 Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.8.2	K 223		
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 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)	K 321		3/20/23

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K 321	Continued From page 4 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 areas in accordance with the 2012 NFPA, Life Safety Code. Failure to maintain hazardous areas as required could result in fire or smoke spread during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 03/01/2023 at 11:10 AM at the biohazard room inside the janitors closet found the rated door was not equipped with a self-closing device. Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2.1.3	K 321	03/20/2023 @ 9:00 am: A door closer was installed to ensure proper closure and compliance on Bio-Hazard door. This will be monitored on a weekly basis by maintenance staff and logged into T.E.L.S by maintenance.	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced	K 919		3/3/23

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K 919	Continued From page 5 by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical equipment as required could increase the risk of electric shock when performing service or repairs. The deficiency could impact all staff or contractors who service the identified equipment. The findings were: Observation on 03/01/2023 at 10:24 AM in the nurse storage room 400 south found that supplies were being stored in front of an electrical panel. A working space of three (3) feet is required to be maintained. Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	03/03/2023 @ 2:00 pm: Maintenance staff moved boxes three (3) feet around the electrical panel and placed a visual red line around the panel to ensure proper space around the electrical equipment. This will be monitored by maintenance weekly and staff using this closet.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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	K 923		3/1/23

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K 923	Continued From page 6 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: Based on observation and staff interview, the facility failed to secure carbon dioxide cylinders in use or storage in accordance with the 2010 NFPA 55, Compressed Gases and Cryogenic Fluids Code. The failure to secure compressed gas cylinders as required may result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. The findings were:	K 923	03/01/2023 @ 2:45 pm: Maintenance staff chained and secured to the wall three (3) bottles of carbon dioxide standing freely in the kitchen next to the ice machine. Kitchen staff and maintenance staff will monitor daily to ensure compliance and safety of bottles.	

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K 923	Continued From page 7 Observation on 03/01/2023 at 12:27 PM in the kitchen found three bottles of carbon dioxide unsecured on the floor. Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 55: Section 7.1.8.4	K 923		