DEPARTMENT OF HEALTH AND HUM[illegible] SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/30/2006

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

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K 000	INITIAL COMMENTS Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a wet sprinkler system and a dry sprinkler branch in the attic. K6: Date of Plan Approval: 1987 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=160;SNF/NF=160 K9: The facility meets the Life Safety Code standards based on an acceptance of a Plan of Correction. "NFPA" National Fire Protection Association	K 000	ACCEPTANCE OF THIS POC WITH DEFICIENCIST, NHA DO 7/5/06 @ 215 PM.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 6/23/06

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.

JUN 26 2006

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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. This STANDARD is not met as evidenced by: Based on observations the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 05/30/06 between 1 PM and 2 PM revealed the following corridor doors had gaps between the top edge of the doors and the door frames which were greater than the allowed 1/8 th of an inch. a. The MDS coordinators' office. b. Occupational therapy kitchen. 3. Observation on 05/30/06 between 1 PM and 2 PM revealed the following corridor doors were equipped with self-closing devices, which were not able to fully latch the doors into the frames:	K 018	K 018 The facility will ensure resident room corridor door openings are less than 1/8th. This will be accomplished by: A) The gap in the doorframe of rooms MDS office and OT kitchen will be reduced to less the 1/8th with a weather stripping material by the maintenance staff. (3) The Frontier and Cheyenne dining room doors will be repaired to that the self-closing device functions properly. B) The maintenance staff will randomly observe room doors and if a gap greater than 1/8th is observed maintenance will immediately reduce the gap with a weather stripping material. 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.	7/12/06

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AT 7/5/06

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K 018	Continued From page 2 a. The Frontier dining room. b. The Cheyenne dining room.	K 018		
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 on observations the facility failed to protect 4 of 12 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3 and 8.3.4.1. The findings were: 1. Observation on 05/30/06 between 1:30 PM and 2 PM revealed the self-closing devices on the following smoke barrier double doors did not fully latch into their door frames: a. Smoke barrier doors near resident room #402. b. Smoke barrier doors near resident room #116.	K 027	K 027 The facility will ensure smoke barriers doors will have at least a 20-minute fire protection rating or are at least 1 ¾ thick solid bonded wood core. A) The smoke barriers doors near resident room 402 and 116 will have the self-closing device repaired so that they close fully. B) The maintenance staff will randomly observe smoke barriers and repair if necessary. 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.	7/12/06

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K 029 SS=D	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 or field-applied 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 on observations the facility failed to provide 1 of 12 hazardous areas with a self-closing door in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 05/30/06 at 1:52 PM revealed the self-closing device on the corridor door to the soiled utility near resident room #125 did not fully latch the door into its frame with each self-closing operation.	K 029	K 029 The facility will ensure hazardous area doors have gaps less than 1/8th and close properly. This will be accomplished by: A) The self-closing device for the soiled utility room near room 125 will be repaired so that it functions properly. FULLY LATCHES INTO THE FRAME. B) The maintenance staff will randomly observe room doors and repair if self-closing device does not function properly. 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.	7/12/06
K 038 SS=D	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:	K 038		

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7/6/06

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K 038	Continued From page 4 Based on observations the facility failed to maintain an 1 of 8 egress exit pathways unobstructed and accessible at all times in accordance with NFPA 101 Section 7.1.10.1. The findings were: 1. Observation on 05/30/06 at 12:19 PM revealed the northwest egress exit pathway to the public way was obstructed by a 6 foot tall wood fence. The door in the fence was locked with a keyed padlock and interview with the maintenance director at the time of observation stated that not all staff were carrying a key to the lock.	K 038	K 038 The facility will ensure exit access is arranged so that exits are readily accessible at all times. This will be accomplished by: A) The maintenance staff has installed a COMBINATION padlock ensuring exit for all parties. (1) B) The maintenance staff will randomly audit to ensure padlock is in place. 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. (1) THE COMBINATION IS POSTED @ THIS LOCK & ALL STAFF ~~ARE AWARE OF THE~~ WERE TOLD THE COMBINATION @ NO IN-SERVICE.	7/12/06

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K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on record review the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The findings were: 1. Review of the fire alarm testing records revealed the annunciator panel's battery load voltage test had not been performed in the last 6 months as required by the Code.	K 051	K 051 The facility will ensure a fire alarm system with approved components, devices or equipment is installed according to NFPA 72. A) The maintenance staff will test the enunciator panel's battery load voltage capacity semi-annually. B) The maintenance staff will randomly audit test records to ensure central semi-annual testing. C) The maintenance staff will report quarterly at the QI meeting any issues with the central station. This will happen for one quarter or until compliance is achieved.	7/12/06

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 1-4.6 and 3-2.7.2 respectively. The findings were: 1. Observation on 05/30/06 between 11:30 AM and 2 PM revealed the following ceiling locations had ceiling tiles missing: a. The kitchen dishwashing room. b. The restroom in resident room #214. c. The restorative office. 2. A sprinkler head with a missing escutcheon plate was observed on 5/30/06 at 11:39 AM in the dietary manager's office.	K 062	K 062 The facility will ensure that an automatic sprinkler system are continuously maintained in reliable operating condition and are inspected and tested periodically in accordance with NFPA. A) Maintenance will replace the ceiling tiles in the kitchen dishwashing room, restroom in resident room 214 and the restorative office. They will also replace the missing escutcheon plate in dietary manager's office. B) Maintenance will randomly audit ceiling tiles and plates ensuring they are in place. C) The maintenance staff will report quarterly at the QI meeting any issues with the ceiling or plates. This will be happen for one quarter or until compliance is achieved.	7/12/06

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K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observations the facility failed to provide an oxygen storage system in accordance with NFPA 99 Section 4-3.1.1.2. and 8.3.1.11.2. The findings were: 1. Observations on 05/30/06 at 11:31 AM revealed more than 8 liquid oxygen tanks were stored in the liquid oxygen transfer room. The liquid oxygen store room contained a total of 16 tanks with a capacity of 103 lbs of liquid oxygen each. The room did not have 3-hour rated walls and corridor door as required for a room storing more than 8 tanks. 2. Observations on 05/30/06 between 12 PM and 12:30 PM revealed 103 pound tanks of liquid oxygen were stored in the following resident	K 143	K 143 The transferring of oxygen: A) Central supply and nursing will ensure that there are no more than 8 liquid oxygen tanks in the transfer room. Central supply and nursing will also ensure that no tanks are stored in resident rooms. B) Central supply and nursing will randomly audit the facility for excess oxygen tanks and remove them if found. C) Maintenance staff will report quarterly at the QI meeting any issues with oxygen storage. This will be happen for one quarter or until compliance is achieved.	7/12/06

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K 143	Continued From page 8 rooms: a. Resident room #324 had one tank stored. b. Resident room #208 had two tanks stored.	K 143		
K 147 SS=D	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 observations the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 370-25 and 400-8, respectively. The findings were: 1. Observation on 05/30/06 at 11:55 AM revealed the electrical receptacle in resident room #408 near bed "A" did not have a cover. 2. Observation on 05/30/06 between 11:30 AM and 2 PM revealed the following areas had flexible temporary wiring in place of fixed permanent wiring: a. The dietary manager's office had an extension cord plugged into a surge protector. The area had insufficient fixed electrical receptacles for the appliances that were in use. b. Resident room #411 had a surge protector attached to the building surface. c. The social services' office had an extension cord supplying power to a computer.	K 147	K 147 The facility will ensure that electrical wiring and equipment is in accordance with NFPA 70. D) Maintenance will replace the electrical receptacle cover in room 408 near bed "A" with a cover. They will also remove temporary wires with fixed permanent wiring in the dietary manager's office, room 411 and social services' office. E) Maintenance will randomly audit electrical wiring and equipment ensuring they are in accordance with NFPA 70. F) The maintenance staff will report quarterly at the QI meeting any issues with the cords or plates. This will be happen for one quarter or until compliance is achieved.	7/12/06