Printed: 06/28/2006
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMA 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 - LIFE CARE CENTER OF CH B. WING _____	06/28/2006

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 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 Federal comparative Life Safety Code (LSC) was conducted June 27-28/2006. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. This building was constructed in 1988. It is of Type V(111) construction, single story with no basement. It is completely sprinklered. The deficiency findings were as follows:	K 000	This plan of correction constitutes Life Care Center of Cheyenne's credible allegation compliance with the Life Safety Code Standard effective 8/10/06.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 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 maintain the 1 hour fire rating of the building. The findings included: 1. It was observed at 10:45 AM on 6/27/06, that a pipe penetrated the upper membrane ceiling of the corridor near room 212. This penetration had an opening of approximately one inch around this pipe. 2. At 4:00 PM on 6/27/06, a hole of approximately 12 inches in diameter was observed in the upper membrane ceiling in resident room 102. The above were confirmed with the maintenance	K 012	K012 The facility will maintain the 1-hour fire rating of the building. 1. The penetration around the pipe near room 212 will be filled with a fire resistant caulk by maintenance. The hole in the upper membrane ceiling near room 102 will be patched with a fire resistant material by maintenance. 2. Maintenance will randomly audit the membrane of the facility to ensure the 1-hour fire rating is maintained. Any penetrations will be immediately repaired. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06

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

X _____ | X Executive Director X 8/9/06

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.

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K 012	Continued From page 1 director at these times.	K 012		
K 018 SS=E	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 upon observation and staff interview during the survey on 6/26/06, it was determined that the facility failed to provide corridor doors that would resist the passage of smoke, and were free of impediments to closing . The findings included: 1. Resident room doors 101, 222, 320, 403, 413, and 415 were observed to be not capable of resisting the passage of smoke.	K 018	K018 Doors protecting corridor openings will be capable of resisting fire for at least 20 minutes. 1. Resident room doors 101, 222, 320, 403, and 416 were repaired by maintenance so that they are smoke resistant by applying a weather stripping to the frame of the door. The latch for doors 325 and 412 were tightened by maintenance to ensure they resist the passage of smoke. Room Doors 118, 215, and 326 were shaved so they do not rub the carpet and have no impediments to closing. 2. Maintenance will randomly audit doors to ensure they will be capable of resisting fire for at least 20 minutes. Maintenance will repair any doors found not to be smoke resistant immediately. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06

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K 018	Continued From page 2 2. Resident room doors 325 and 412 were loose after latching causing them to not be capable of resisting the passage of smoke. 3. Resident room doors 118, 215, and 326 were observed as rubbing on the carpet thresholds causing them to not be free of impediments to closing.. The above were verified with the maintenance director at the of discovery.	K 018		
K 027 SS=E	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 1 of 6 sets that would resist the passage of smoke. The findings included: 1. It was observed at 1:30 PM on 6/27/06, that one of the smoke doors in the set located	K 027	K027 Doors protecting corridor openings will be capable of resisting fire for at least 20 minutes. 1. Maintenance repaired the latch on the door between resident rooms 115 and 116 ensuring it latches. 2. Maintenance will randomly audit doors to ensure they will be capable of resisting fire for at least 20 minutes. Maintenance will repair any doors found not to be smoke resistant immediately. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06

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K 027	Continued From page 3 between resident rooms 115 and 116 was not resisting the passage of smoke due to the fact that it was not latching when it was allowed to close. This was verified with the maintenance director at this time.	K 027		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based upon observation and staff interview during the survey on 6/27/06, it was determined that the facility failed to provide emergency lighting in accordance with LSC 7.9., NFPA 70,700-12(b)(1), & NFPA 70, 517-32 (e). The findings included: It was observed during the afternoon of 6/27/06, that a battery emergency light was not provided at the emergency generator transfer switch. This was verified with the maintenance director at that time.	K 046	K046 Emergency lighting in accordance with 7.9 will be provided. 1. Maintenance will install emergency lighting at the emergency generator transfer switch. 2. Maintenance will randomly audit the emergency lighting to ensure light is functioning properly. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06

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K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based upon observation, record review, and staff interview, it was determined during the survey, that the facility failed to install heating, ventilating, and air conditioning equipment in accordance with the manufacturer's specifications. The findings included: 1. At approximately 4 PM on 6/27/06, it was observed that a duct had come apart above the corridor ceiling near resident room 101. 2. Record review and staff interview during the survey indicated that a schedule for exercising the fire dampers in the building once every 4 years had not been established. This was verified with the maintenance director at that time.	K 067	K067 The facility will install HVAC equipment in accordance with the manufacturer's specifications. 1. Maintenance repaired and reconnected the duct above the ceiling near room 101. Maintenance also exercised the fire dampers and will do so at least every four years. 2. Maintenance will randomly audit the HVAC system to ensure manufacturer's specifications are in accordance as part of our preventive maintenance program. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06

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K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This Standard is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined the facility failed to provide precautionary signs where oxygen was being administered. The findings included: 1. Oxygen was observed being administered throughout the facility at resident rooms including , but not limited to, 121, 203, 204, 206, 209, 210, 211, 221, 224, 225, 226, and 228 without any precautionary signs being provided. This was verified with the maintenance director at the times they were observed.	K 076	K076 The facility will provide precautionary signs where oxygen is being administered. 1. Central Supply will post magnetic "Oxygen In Use" signs throughout the facility wherever oxygen is being administered. 2. Administration will randomly audit the "Oxygen is Use" signs to ensure compliance. Signs will be immediately posted if found to be missing. 3. Any findings will be reported at Quality Assurance meeting for three months or until ongoing compliance is established.	8/8/06