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

PRINTED: 09/22/2008
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 - MAIN BUILDING 01 B. WING ______	09/10/2008

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 the 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 built in 1987. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system.	K 000	POC ACCEPTED WITH DOTEL SCHMIDT, NAHD 10/15/08 [signature]	
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 on observation and staff interview the facility failed to ensure ceilings were smoke resistant in one of six smoke compartments. The findings were: Observation on 9/10/08 at 10:21 AM revealed a ceiling tile was missing in the south hall mechanical room. Interview with the maintenance director at the time of observation revealed every room was inspected monthly to ensure they were smoke resistant.	K 012	K 012 Building and construction type will meet NFPA guidelines. A) Missing ceiling tile in South hall mechanical room was moved into place during survey. B) Maintenance will ~~randomly~~ audit ceiling tiles to ensure they are in place and areas are smoke resistant, quarterly [initials] 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.	10/21/08
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	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 10.1.08

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 025	Continued From page 1 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 two of six smoke barrier walls were smoke resistant. The findings were: 1. Observation on 9/10/08 between 12:30 PM and 1 PM revealed the following smoke barrier walls had unsealed cable penetrations: a. The barrier wall in the ceiling cavity above resident room #402 had two unsealed cable penetrations. b. The barrier wall in the ceiling cavity above resident room #112 had two unsealed cable penetrations. 2. Interview with the maintenance director on 9/10/08 at 12:50 PM revealed the barrier walls were inspected quarterly, but the walls in the resident rooms were not routinely inspected.	K 025	K 025 Smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. A) The smoke barrier penetrations above rooms #402 and #112 were covered with ½ inch sheetrock screwed in on both sides as discussed with surveyor. Penetrations in attic were filled with a fire resistant caulk. B) The maintenance staff will ~~randomly~~ audit smoke barrier walls and ceiling cavity above resident rooms quarterly and repair any found penetrations to ensure smoke resistance. quarterly. C) The maintenance staff will report annually at the QI meeting the findings of their observations. This will happen for one quarter or until compliance is achieved.	10/21/08
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	K 029	K 029 Areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-related or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted.	10/21/08

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K 029	Continued From page 2 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 observation and staff interview the facility failed to ensure hazardous areas were separated from residential areas by smoke resistant partitions in one of six smoke compartments. The findings were: Observation on 9/10/08 at 11:09 AM revealed the automatic closing device attached to the south hall soiled linen room corridor door did not function adequately to ensure the door seated in its frame. Three attempts were made to close the door with the device, and all three were unsuccessful. Interview with the maintenance director at the time of observation revealed all hazardous areas were inspected monthly to ensure proper separation.	K 029	A) The self-closing device for the south hall soiled utility room was adjusted to close properly during survey. B) The maintenance staff will ~~randomly~~ observe room doors and repair if self-closing device does not function properly, quarterly 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 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit signs were properly	K 047	K 047 Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system. A) Exit lights were replaced with new L.E.D. models. B) The maintenance staff will ~~randomly~~ observe Exit lights and replace bulbs as needed. monthly	10/21/08

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K 047	Continued From page 3 illuminated in one of six smoke compartments. The findings were: 1. Observation on 9/10/08 between 1 PM and 2 PM revealed one of two light bulbs in the following exit signs were not illuminated: a. The exit sign in the main dining room. b. The exit sign in the kitchen near the service corridor. 2. Interview with the maintenance director on 9/10/08 at 1:30 PM revealed the exit signs were inspected monthly to ensure proper illumination.	K 047	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 062 SS=F	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	K 062	K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.	10/21/08
	This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure three of seven sprinkler system components were tested quarterly. The findings were: 1. Review of the sprinkler system testing records revealed the waterflow, supervisory signal and main drain devices had not been tested during the first quarter of 2008. 2. Interview with the maintenance director on 9/10/08 at 2:50 PM revealed he did not have testing records on the sprinkler system for the first quarter of 2008. Further review revealed the testing contractor confirmed the components had		A) Quarterly test was done on 5/1/08 when system was replaced. B) The maintenance staff will audit quarterly to ensure test has occurred. 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.	

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K 062	Continued From page 4 not been tested during the first quarter of 2008.	K 062		
K 143 SS=E	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 observation and staff interview the facility failed to ensure liquid oxygen tanks were properly stored in one of six smoke compartments. The findings were: 1. Observation on 9/10/08 at 11:45 AM revealed the vent in the liquid oxygen storeroom was plugged with lint. Further review revealed the light switch was not 60 inches above the floor. The light switch was only 48 inches above the floor. Interview with the maintenance director at the time of observation revealed he was unaware of the requirements for liquid oxygen storerooms.	K 143	K 143 Transferring of oxygen is: A) 1) Vent was cleaned during survey. 2) Light switch moved to 60 inches above floor on 9/17/08. 3) Oxygen tanks in central supply were removed during survey. B) The maintenance staff will ~~randomly~~ audit and clean oxygen room vent to ensure correct air exchange. quarterly. Maintenance will also audit Central Supply randomly to ensure no storage of liquid oxygen tanks. 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.	10/21/08

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K 143	Continued From page 5 2. Observation on 9/10/08 at 12:10 PM revealed nine liquid oxygen tanks were being stored in central supply. The area was not equipped with a mechanical ventilation system, and the tanks were stored within five feet of combustible material. Interview with the administrator revealed the tanks were being stored in central supply due to the lack of space in the oxygen storeroom. He further reported that transferring of liquid oxygen only occurred in the oxygen storeroom.	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 observation and staff interview the ~~facility failed to ensure temporary electrical wiring~~ did not replace permanent wiring in two of six smoke compartments. The findings were: 1. Observation on 9/10/08 between 9 AM and 11 AM revealed the following areas had temporary electrical wiring being used in place of permanent wiring: a. The computer in the administrators' office was plugged into a surge protector, which was, itself, plugged into another surge protector. b. The computer in the payroll office was plugged into a surge protector, which was, itself, plugged into another surge protector. C. The lamp in resident room #211 was plugged into an extension cord. 2. Interview with the maintenance director on 9/10/08 at 9:14 AM revealed the electrical system	K 147	K 147 Electrical wiring is in accordance with NFPA 70. A) Surge protectors in administrators and payroll office was plugged into wall during survey. The resident lamp in room #211 was also plugged into the wall and extension cord was removed. B) ~~The maintenance staff will randomly~~ audit surge protectors to ensure that they are used correctly and that extension cords will not be used in the facility, QMMEETING 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.	10/21/08

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K 147	Continued From page 6 was inspected monthly.	K 147		