

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 Nursing Homes Section 42 CFR 483.70 (a) 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, two-story building with a basement of Type V (111) construction built in 1920, 1972, and 1993. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 74 residents.	K 000			
K 133 SS=E	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by:	K 133		2/2/18	

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

TITLE

(X6) DATE

Electronically Signed

01/18/2018

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.

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 133	Continued From page 1 Based on observation and staff interview, the facility failed to maintain occupancy separation in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 12/19/2017 at 12:45 PM located in the apartment stairway revealed a 1-hour rated door separating the apartment from the nursing home. Further observation revealed that the second stairway leading to the apartment also had a 1-hour rated door. Failure to maintain a 2-hour separation between the apartment and the nursing home could cause fire spread increasing the risk of injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101, Section: 19.1.3.3	K 133	K133 The doors located in the apartment stairway will be replaced with fire rated 2 hour separation door by maintenance on or before date of compliance. NHA will educate maintenance on maintaining occupancy separation in accordance with 2012 NFPA 101, Life Safety Code. Maintenance Director/designee will monitor apartment doors for compliance weekly for 4 weeks. Once compliance is sustained maintenance/designee will monitor apartment doors compliance monthly. Any non compliance will be corrected and re-educating completed by NHA/designee. Issues and concerns and results from monitoring will be reviewed in QA/A until compliance is sustained. A request for a wavier extension attached.		
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		2/2/18	

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 211	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide locks in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 12/19/2017 at 8:47 AM in Room 64 (Copy Room) revealed that the lock for the door was on the hallway side of the door, which could allow someone to be locked inside the room. Failure to provide locks as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101, Section: 7.2.1.5.1 2. Observation on 12/19/2017 at 8:58 AM in the Activities Room revealed that the doors leading to the exit corridor had multiple locks. Further observation in the Dining Room revealed that the doors leading to the exit corridor also had multiple locks. Failure to provide locks as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.5.10.2 3. Observation on 12/19/2017 at 1:17 PM in the Kitchen revealed an exit door with two doorknobs with locks requiring more than one releasing action to open. Failure to provide locks as required could result in injury or death during an emergency. Interview with the Facility	K 211	K211 1. The copy room doorknob was replaced with a no locking doorknob by maintenance before date of compliance. 2. The Activity Room and Dining Room door locks were removed by maintenance before the date of compliance. 3. One Kitchen exit door lock was removed and one new lock installed which allows one releasing action to open by maintenance before date of compliance. 4. The tight pinching door lock in the Kitchen was removed by maintenance. 5. Maintenance Director will receive verification that an annual fire door assembly inspection was completed. Maintenance Director scheduled another inspection on the annual fire door assembly. Maintenance Director/designee will monitor and approve all door knobs that will be installed. Maintenance Director/designee will monitor 10 doors a month until compliance achieved. Any non compliance will be corrected at time of audit. Any issues or concerns will be brought to QA/A A wavier extension attached for #5		

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 211	Continued From page 3 Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.5.10.2 4. Observation on 12/19/2017 at 1:20 PM revealed tight pinching door locks in the Kitchen. Further observation revealed tight pinching door locks throughout the facility. Failure to provide locks as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.5.10.2 5. Document review on 12/19/2017 at 1:30 PM revealed that the facility could not verify that the required annual fire door assembly inspection had been completed. Failure to maintain fire door assemblies as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Section: 8.3.3.1 2010 NFPA 80 Section: 5.2.1	K 211			
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341			2/2/18

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070	
(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 341	Continued From page 4 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install a fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. The findings were: Observation on 12/19/2017 at 1:26 PM in Boiler Room #2 revealed that the electrical panel lacked red labeling or a red breaker indicating the fire alarm. Marking the fire alarm breaker with red will expedite locating the correct breaker in an emergency, or prevent power loss to the system. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement.	K 341	K-341 Red fire marking was placed in boiler room #2 electrical panels were placed by maintenance before the date of compliance. Maintenance director/designee will monitor the required marketing on the boiler room #2 electrical panel remains intact by monitoring monthly. Maintenance Director will monitor for compliance and bring and issues or concerns to QA/A	
K 343 SS=D	REF: 2012 NFPA 101, Section 9.6.1.3 2010 NFPA 72, Section: 10.5.5.2.3 Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING	K 343		2/2/18

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070	
(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 343	Continued From page 5 Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm notification in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. The findings were: Document review on 12/19/2017 at 1:30 PM revealed that the facility was unable to verify that each strobe and horn had passed visual and audible inspection on an annual basis. Failure to provide annual testing for fire alarm components as required increases the risk of injury or death due to fire. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101, Section: 19.3.4.4; 9.6.3 2010 NFPA 72, Section 14.4.2.2	K 343	K-343 Maintenance Director will obtain the required documentation verifying that each strobe and horn passes visual and audible inspection on or before the date of compliance. The maintenance director/designee will monitor that this test is performed annually by reviewing test schedules along with keeping the required documentation to show compliance. Any missing documentation or will be corrected at time of the audit. The Maintenance Director will monitor for compliance and bring any issues to QA/A.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		2/2/18

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 363	Continued From page 6 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety	K 363	K-363 The fire doors adjacent to oxygen room in Oak Hall will receive approved fire		

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 363	Continued From page 7 Code. The findings were: Observation on 12/19/2017 at 9:23 AM at the fire doors adjacent to the Oxygen Room in Oak Hall revealed the doors would not latch when tested. Further observation revealed that the doors lacked fire door hardware. Failure to provide fire doors as required increases the risk of death or injury due to fire. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Section 19.3.6.3.5	K 363	hardware along with added door latching function on or before date of compliance by maintenance. Maintenance director/designee will monitor and approve of any new hardware to be installed in facility to ensure compliance. Maintenance director/designee will monitor hardware on fire doors monthly until compliance is sustained. The maintenance director will monitor for compliance and bring any issues to QA/A		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilation Systems. The findings were: Observation on 12/19/2017 at 8:41 AM in the	K 521	K-521 On or before date of compliance the fire dampers will be opened by a professional HVAC specialist in the Central Supply Room, Activities Room and Oak Hall adjacent to room.	2/2/18	

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GBMY21 Facility ID: WY0006 If continuation sheet Page 9 of 12

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070	
(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 753	Continued From page 9	K 753		
K 911 SS=D	Observation on 12/19/2017 at 10:43 AM in Room 33 revealed more than 50 percent of the resident's wall covered by combustible decorations. Failure to maintain combustible decorations as required could result in fire spread resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101, Section: 19.7.5.6 (d) Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 79, Electrical Standards for Industrial Machinery. The findings were: Observation on 12/19/2017 at 9:50 AM at the generator emergency stop button located in the corridor adjacent to the nurse's station revealed a box placed over the button. Further observation revealed that the box was locked, and the key was located in a drawer in the nurse's desk.	K 911	The leadership team , activities, admissions and maintenance department will be re-educated on combustible decorations by maintenance director? Maintenance/designee will do random audits of 10 rooms monthly to ensure compliance for three months and PRN thereafter once compliance is achieved. The Maintenance Director/Designee will monitor for compliance and bring any issues to QA/A K-911 Before date of compliance the box covering the generator emergency stop button located in the corridor adjacent to the nurses station has been removed by maintenance. On or before the date of compliance the facility leadership team will be educated on the function of the emergency stop button. Maintenance/Designee will monitor the absence of a box or other obstacles placed over the button monthly and report non-compliance in QA/A	1/26/18

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070	
(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 911	Continued From page 10 Interviews with staff indicated not all staff knew where the key was located. Initiation of the emergency stop function must consist of only a single action. Failure to maintain electrical systems as required could delay shutting down the generator resulting in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement.	K 911		
K 916 SS=D	REF: 2012 NFPA 101, Section: 9.1.3 2012 NFPA 79, Section 9.2.5.4 (1) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical systems in accordance with the 2012 NFPA 99, Health Care Facilities Code. The findings were: Observation on 12/19/2017 at 9:50 AM at the generator annunciator panel located in the corridor adjacent to the nurse's station did not have a test switch to verify the illumination of the bulbs. Failure to provide essential electrical power	K 916	K916 On or before date of compliance a Generator Specialist will replace the generator annunciator panel with a panel that has a test switch to verify the illumination of the bulbs. Maintenance Director/Designee will monitor generator panel monthly for	1/26/18

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 916	Continued From page 11 components as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 99, Section: 6.4.1.1.17.4 (4)	K 916	compliance. Maintenance Director/Designee will monitor for compliance and bring issues and concerns to monthly QA/A		

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

PRINTED: 12/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2017
NAME OF PROVIDER OR SUPPLIER LARAMIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 503 S 18TH ST LARAMIE, WY 82070		
(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 December 19, 2017. Based upon the findings of the survey team, it was determined the facility was in compliance with all Emergency Preparedness requirements.	E 000			

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

TITLE

(X6) DATE

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.