STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	**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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on December 18, 2018. 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 73 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	K 133		2/2/19

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

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	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

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K 133	Continued From page 1 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: Based on observation and staff interview, the facility failed to maintain occupancy separation in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain occupancy separation as required could cause fire spread resulting in injury or death. The deficiency affected less than 10 percent of the facility, as well as the 185 residents and staff. The findings were: Observation on 12/18/2018 at 10:20 AM located in the apartment stairwell revealed a 45-minute rated door instead of the required 90-minute rated door. Further observation revealed that the second stairwell leading to the apartment also had a 45-minute rated door. This deficiency was also identified during the previous Life Safety Code survey. Interview with the facility maintenance manager at the time of observation acknowledged the 45-minute door, and indicated awareness of the requirement. He stated that the doors were scheduled to be replaced, but the contractor backed out of the project. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.1.3.3 .	K 133	K133 Corrective Action: The doors located in the apartment stairway will be replaced with 90 minute rated door by a contractor on or before the date of compliance. Identification: All resident have the potential of risk. Systematic Changes: 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. Non-compliance will be review in QAPI Date of compliance 2/2/2019	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101	K 211		2/2/19

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	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	**503 S 18TH ST LARAMIE, WY 82070**

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K 211	Continued From page 2 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress during an emergency resulting in injury or death. The deficiency affected 2 of 8 exits, as well as the 185 residents and staff. The findings were: 1. Observation on 12/18/2018 at 9:09 AM at the main entrance to the facility revealed a congested corridor with residents in wheelchairs parked wheel-to-wheel across the corridor. Further observation revealed no staff members in the vicinity. Interview with the facility maintenance manager at the time of observation acknowledged the congestion, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.1; 7.1.10.1; 4.5.3.2 2. Observation on 12/18/2018 at 10:30 AM in the stairwell leading to the apartment revealed a tight	K 211	K211 Corrective Action: Residents were redirected to areas that were not congesting the means of egress. Identification: All residents have the potential of risk Systematic Changes: NHA/Designee will Re-educated staff on the means of egress. Maintenance Director/Designee will monitor means of egress compliance three times a week for three months and weekly thereafter. Any non-compliance will be corrected and re-education completed by Maintenance/designee. Non-compliance will be reviewed in QAPI. Date of compliance 2/2/2019	

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	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 211	Continued From page 3 pinching door lock that required more than one operation to open. Interview with the facility maintenance manager at the time of observation acknowledged the door lock, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.5.10.2 .	K 211		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to maintain fire alarm systems as required could result in injury or death during an emergency. The deficiency affected 1 of 3 (alarm initiating, supervisory alarm initiating, and notification) testing requirements of the fire alarm system, as well as the 185 residents and	K 345	K345 Corrective Action: 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. Systemic Changes: The maintenance director/designee will monitor that this test is performed annually by reviewing test	2/2/19

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	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

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K 345	Continued From page 4 staff. The findings were: Document review on 12/18/2018 at 3:00 PM revealed that the facility could not verify that each horn and strobe notification device had passed visual and audible inspection on an annual basis. This deficiency was also identified during the previous Life Safety Code survey. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.4.1; 9.6.1.5 2010 NFPA 72, Sections: 14.4.5(20); 14.6.2.4; Figure 14.6.2.4 page 11	K 345	schedules along with keeping the required documentation to show compliance. Any missing documentation will be cored at time of the audit. The Maintenance Director will monitor for compliance and bring any issues to QAPI Date of compliance 2/2/2019	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		2/2/19

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K 353	Continued From page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Protection Systems. Failure to maintain fire sprinkler systems as required could result in injury or death during an emergency. The deficiency affected 100 percent of the attic area of the facility, as well as the 185 residents and staff. The findings were: Observation on 12/18/2018 at 10:04 AM above the IT room revealed attic insulation falling down and obstructing the fire sprinkler heads. Further observation revealed the issue was prevalent throughout the attic area. Interview with the facility maintenance manager at the time of observation acknowledged the falling insulation, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section: 5.2.1.1.1	K 353	K353 Corrective Action: attic insulation that was falling down above the IT room was repaired before date of compliance by Maintenance Director. Maintenance Director/Designee will monitor attic insulation weekly for three months and once monthly thereafter. Noncompliance will be corrected at time of audit any continued noncompliance will be reviewed in QAPI. Date of compliance 2/2/2019	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101	K 753		2/2/19

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K 753	Continued From page 6 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain combustible decorations as required could cause fire spread resulting in injury or death. The deficiency affected less than 10 percent of the facility, as well as the 185 residents and staff. The findings were: Observation on 12/18/2018 at 11:13 AM in room 53 revealed a live evergreen wreath on the back of the corridor door. Interview with the facility maintenance manager at the time of observation acknowledged the live wreath, and indicated awareness of the requirement.	K 753	K753 Corrective Action: The live evergreen wreath on the back of the corridor door in room 53 was removed at time of survey. Systemic Changes: Maintenance Director/Designee will re-educate team members on combustible decorations that are prohibited. Maintenance Director/Designee will monitor facility and resident decorations weekly for three months and monthly. Any noncompliance will be corrected at time of the audit and any reviewed in QAPI. Date of compliance 2/2/2019	

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K 753	Continued From page 7 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.7.5.6 .	K 753		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain portable heaters in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain portable heaters as required could cause a fire resulting in injury or death. The deficiency effected less than 10 percent of the facility, as well as the 185 residents and staff. The findings were: Observation on 12/18/2018 at 10:06 AM in room 17 revealed a portable heater plugged in and operating. Portable heaters are permitted only in nonsleeping staff and employee areas. Interview with the facility maintenance manager at the time of observation acknowledged the portable heater, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 781	K781 Correction Action: Portable space heater in resident's room 17 was removed at time of survey. Systemic Changes:Maintenance Director /Designee will re-educate staff on space heaters being prohibited in sleeping rooms. Maintenance Director/Designee will monitor sleeping rooms weekly for three months and monthly thereafter. Any noncompliance will be corrected at time of audit. Any noncompliance will be discussed in QAPI. Date of compliance 2/2/2019	2/2/19

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K 781	Continued From page 8 REF: 2012 NFPA 101, Section: 19.7.8	K 781		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		2/2/19

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K 918	Continued From page 9 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to maintain emergency generators in accordance with the 2012 NFPA 99, Health Care Facilities, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to maintain emergency generators as required could result in injury or death during an emergency. The deficiency affected 1 of 1 emergency generators, as well as the 185 residents and staff. The findings were: Document review on 12/18/2018 at 3:00 PM revealed the facility could not verify that a monthly or annual load bank test had been conducted on the emergency generator. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Sections: 6.4.4; 6.5.4; 6.6.4 2010 NFPA 110, Sections: 8.4.2; 8.4.2.3	K 918	K918 Corrective Action: Facility will maintain monthly conductance generator battery test on the gas powered emergency generator on or before the date of compliance. Systemic changes: Maintenance Director and Maintenance Assistant will be educated by the NHA on the requirement of the monthly conductance emergency generator battery testing. The Maintenance Director/Designee will document the monthly testing for compliance. The NHA/Designee will monitor for compliance and bring issues and concerns to monthly QAPI. Date of compliance 2/2/2019	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on December 18, 2018. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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

Electronically Signed | 01/07/2019

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.