STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/18/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	**4041 SOUTH POPLAR STREET** **CASPER, WY 82601**

(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 June 18, 2019. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction with plan approval in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 92 residents. .	K 000		
K 211 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire	K 211	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	7/20/19

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

Electronically Signed | 07/12/2019

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.

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K 211	Continued From page 1 Doors and Other Opening Protectives. Failure to maintain means of egress as required could result in injury or death during an emergency. The deficiency affected seven (7) of seven (7) smoke compartments. The findings were: Document review on 6/18/2019 at 2:12 PM revealed the facility could not verify that the required annual fire door assembly inspection had been completed during the previous 12 months. 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, Section: 8.3.3.1 2010 NFPA 80, Section: 5.2.1 .	K 211	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the state operations manual. K-211 1. The facility cannot go back retrospectively to provide verification that the required annual fire door assembly inspection had been completed during the previous 12 months. 2. The Maintenance Director or designee will conduct the annual fire door assembly inspection on or before July 20, 2019. 3. The Maintenance Director or designee will complete an audit to ensure the fire door assembly inspections are completed annually. 4. A Performance Improvement tool will be utilized to report these audits. The results/findings will be reviewed at each of the facility's Performance Improvement Committee meetings. 5. Compliance met on or before July 20, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/18/2019**

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LIFE CARE CENTER OF CASPER	**4041 SOUTH POPLAR STREET** **CASPER, WY 82601**

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K 222	Continued From page 2	K 222		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems	K 222		7/20/19

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	535049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/18/2019**

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K 222	Continued From page 3 installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected two (2) of seven (7) facility exits. The findings were: Observation on 6/18/2019 at 10:35 AM at door 3 revealed the delayed egress locking system failed to operate as designed. When tested the release process failed to activate an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds. Further observation at the exit in the main lobby revealed	K 222	K- 222 1. Maintenance Director or designee ensured door 3 and main door functioned properly on 6/19/2019. 2. All other delayed egress doors were checked to ensure they function properly. 3. The Maintenance Director or designee will complete a monthly audit to ensure delayed egress doors function properly. 4. A Performance Improvement tool will be utilized to report these audits. The	

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	535049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/18/2019**

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K 222	Continued From page 4 the delayed egress locking system, when tested, failed to activate an audible signal, and failed to release after 15 seconds. Both doors could only be released by punching in a code. 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: 19.2.2.2.4; 7.2.1.6.1.1 (3) .	K 222	results/findings will be reviewed at each of the facility's Performance Improvement Committee meetings. 5. Compliance met on or before July 20, 2019.	
K 345 SS=D	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 observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were:	K 345	K-345 1. The facility cannot retrospectively show proof of current Underwriter's Laboratory certification for the fire alarm. 2. The facility obtained a copy of the Underwriter's Laboratory certification for	7/20/19

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K 345	Continued From page 5 Observation on 6/18/2019 at 1:20 PM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm expired on 31 March 2019. Further observation revealed that a current certification was not in the fire alarm system documentation. Interview with the facility maintenance manager at the time of observation acknowledged the expired certification, and indicated he was unaware 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; 9.6.1.3 .	K 345	the fire alarm, expiration of March 31, 2020. 3. The Maintenance Director or designee will conduct an annual audit to ensure Underwriter's Laboratory certification for the fire alarm remains current. 4. A Performance Improvement tool will be utilized to report these audits. The results/findings will be reviewed at each of the facility's Performance Improvement Committee meetings. 5. Compliance met on or before July 20, 2019.	
K 521 SS=F	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 document review and staff interview, the facility failed to maintain HVAC systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to	K 521	K-521 1. The facility cannot retrospectively show proof of fire damper testing during the previous 48 months.	7/20/19

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K 521	Continued From page 6 provide HVAC systems as required could result in fire and smoke spread resulting in injury or death. The deficiency affected seven (7) of seven (7) smoke compartments. Document review on 6/18/2019 at 1:56 PM revealed the facility could not verify that the fire dampers had been tested during the previous 48 months. 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: 19.5.2.1, 9.2.1 2010 NFPA 80, Section: 19.4.1.1	K 521	2. The facility obtained copies of fire damper inspections during the previous 48 months from our contract vendor. 3. Maintenance Director or designee will conduct annual audits to ensure that the fire dampers are tested every 48 months. 4. A Performance Improvement tool will be utilized to report these audits. The results/findings will be reviewed at each of the facility's Performance Improvement Committee meetings. 5. Compliance met on or before July 20, 2019.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		7/20/19

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K 914	Continued From page 7 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) of one (1) testing requirement. The findings were: Document review on 6/18/2019 at 2:10 PM revealed the facility could not verify that non-hospital grade receptacles in the patient care areas had been tested within the past 12 months. 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: 6.3.4.1.3; 6.3.3.2	K 914	K-914 1. Non-hospital grade receptacles in the patient care areas have been tested on or before July 20, 2019. 2. All non-hospital grade receptacles in the patient care areas will be tested annually. 3. Maintenance Director or designee will conduct annual audits to ensure that the non-hospital receptacles are tested every 12 months. 4. A Performance Improvement tool will be utilized to report these audits. The results/findings will be reviewed at each of the facility's Performance Improvement Committee meetings. 5. Compliance met on or before July 20, 2019.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on June 18, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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Electronically Signed | 07/08/2019

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