

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on June 10, 2021. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements.	E 000	See Attached Doc For POC		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on June 9 and 10th, 2021. 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 75 residents.	K 000			
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the	K 223			

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

TITLE

(X6) DATE

T-B-D

Executive Director

7/12/21

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.

POC Accepted via phone call with Administrator Tess Bailey on 7/16/21 at 11:25 am *41673

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

PRINTED: 07/02/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 223	Continued From page 1 closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching self-closing door as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous doors in the facility. The findings were: Observation on 3/9/2021 at 4:11 PM at the storage room next to nurses station unit #1, revealed that the door failed to latch when it was released from a fully open position. Additional observation found the rated fire door between the mechanical boiler room and the staff corridor failed to latch when it was released from a fully open position. Interview with the 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 7.2.1.8.2	K 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 223	Continued From page 2	K 223			
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous corridors in the facility. The findings were: Observation on 6/9/2021 at 3:10 PM in the east corridor by rooms 205 and 208 looking towards the nurses station revealed that no exit sign could be observed in the corridor. Additional observation by rooms 115 and 114 looking towards the nurses station revealed that no exit sign could be observed in the corridor. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 293			

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

PRINTED: 06/10/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 293	Continued From page 3 REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.1.1, 7.10.1.5.1	K 293			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321			

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

 PRINTED: 06/23/2021
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2021	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 4 1. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous hazardous areas in the facility. The findings were: Observation on 6/9/21 at 4:35 PM at the activities storage area revealed that the interior door leading to the larger storage area was not self-closing as required for sprinklered storage areas. Interview with the 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 19.3.2 2. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 6/9/2021 at 5:10 PM at the rated laundry room door off of the employee corridor revealed the UL frame rating was missing for a complete fire door assembly. Interview with the maintenance manager at the time of observation acknowledged the deficiency.			K 321			

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 5 and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Sections 19.3.2; 8.7.1; 8.3.3.1; Table 8.3.4.2	K 321			
K 345 98-D	Fire Alarm System - Testing and Maintenance GFR(e): 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 test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 06/10/21 at 10:15 AM revealed that the quarterly water flow alarm devices testing was not available to two quarters in 2020, with documentation provided for 1/5 and 4/12 of 2021. Interview with the maintenance manager at the	K 345			

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

 PRINTED: 08/23/2021
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 6 time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 72: Section 13.2.6.1 2011 NFPA 25 Table 5.1.1.2; 5.3.3.1	K 345			
K 353 SS=D	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 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 document review and staff interview, the facility failed to test and maintain the automatic sprinkler system in accordance with the 2011 NFPA 25, Standard for the Inspection,	K 353			

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

PRINTED: 06/23/2021
FORM APPROVAL
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 7 Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain the automatic sprinkler system could result in injury or death in the event of a fire. The deficiency affected the dry systems of the automatic sprinkler system. The findings were: Document review on 06/10/21 at 10:15 AM revealed that the quarterly priming water, low air alarm, and quick opening devices testing was not available to two quarters in 2020, with documentation provided for 1/5 and 4/12 of 2021. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2011 NFPA 25 Sections 13.4.4.2.1, 13.4.4.2.6, 13.4.4.2.4	K 353			
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct fire extinguisher inspections in accordance with the 2010 NFPA	K 355			

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

PRINTED: 06/23/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 355	Continued From page 8 10. Standard for Portable Fire Extinguishers. Failure to conduct fire extinguisher inspections as required may result in injury or death during an emergency. The deficiencies affected two (2) of numerous fire extinguishers in the facility. The findings were: Observation on 6/9/2021 at 3:51 PM by room 227 found the fire extinguisher not signed off or inspected since April of 2021. Further observation found an additional fire extinguisher by room 115 where the signoff for May of 2021 was missing. Interview with the 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: 2010 NFPA 10: Section 7.2.1; 7.2.4	K 355			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced	K 511			

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

PRINTED: 06/23/2021
FORM APPROVAL
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 511	Continued From page 9 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 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 6/9/2021 at 5:00 PM in the storage/employee break room revealed a junction box without a cover above the ceiling. 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: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)	K 511		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		

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

PRINTED: 06/23/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 712	Continued From page 10 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills could result in injury or death in the event of a fire. The deficiency affected the entire facility. The findings were: Document review on 6/10/21 at 10:00 AM revealed the only two fire drills were conducted in the 4th quarter of 2020 (October and December of 2020 were conducted). Fire drills are required to be conducted 3 times per quarter on a rotating shift schedule. No documented training program could be found that occurred in lieu of this drill. Interview with the facilities manger at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Sections 19.7.1.6	K 712			
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies; at showers and baths; on windows in	K 751			

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

PRINTED: 06/23/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 4041 SOUTH POPLAR STREET CASPER, WY 82501		
(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 751	Continued From page 11 patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide patient curtains in accordance with the 2012 NFPA 101, Life Safety Code. The failure to provide patient curtains as required could contribute to the spread of fire, resulting in injury or death. The deficiencies affected the entire facility. Observation on 6/9/2021 at 4:29 PM in room 122 found the privacy curtains did not state they meet the requirements of NFPA 701. Curtains are present throughout the facility. The curtains did state that they are "permanently flame retardant," but the facility did not have paperwork to establish that the curtains satisfied the requirements of NFPA 701. 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: 19.7.5.1; 10.3.1	K 751			
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 923	Continued From page 12 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923			

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

PRINTED: 06/23/2021
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 06/10/2021
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CASPER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 923	Continued From page 13 Based on observation and staff interview, the facility failed to provide ventilation for areas storing or transfilling medical gases in accordance with the 2012 NFPA 99, Health Care Facilities Code. The failure to maintain medical gas storage or transfilling as required could result in injury or death. The deficiency affected one (1) of one (1) medical gas storage and transfilling locations in the facility. The findings were: Observation on 6/9/2021 at 5:05 PM in the medical gas storage and transfilling room revealed that the room was provided with ductwork going to within 1 foot of the floor, but it could not be determined that air was being pulled from the space at an appropriate rate. The room contained greater than 3000 cubic feet of Oxygen at time of survey. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Sections: 9.3.7.5.3.2	K 923			

Life Care Center of Casper Life Safety Survey Plan of Correction 6.10.21

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 alleged or conclusions set forth in 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 facilities' allegation of compliance in an accordance with the state operations manual.

K 223

- 1.) Maintenance Director or designee repaired the latch mechanism on both doors cited in the deficiency on 7/2/21.
- 2.) Maintenance Director or Designee completed an initial audit on 7/1/21 of all fire rated doors in the facility to ensure compliance is met, no other issues were identified related to this deficiency.
- 3.) Maintenance Director or designee will complete a monthly audit of all fire rated doors in the facility to ensure compliance is met.
- 4.) Maintenance Director or designee will complete the audit monthly and will report results at the facilities monthly PI meeting for at least 90 days or until substantial compliance is met.
- 5.) Compliance will be met on or before July 3, 2021.

K293

- 1.) Maintenance Director or designee will place exit signs in all necessary areas to ensure continuous illumination in facility corridors. Modern Electric is currently working on a bid for this project.
- 2.) Maintenance director or designee completed an initial audit on 7/1/21 to determine if compliance is met in all other areas of the facility related to this deficiency. It was identified that one additional exit sign was needed in order to become compliant.
- 3.) Initial audit will be sufficient to ensure compliance.
- 4.) Results of audit will be reported in facilities August 2021 PI meeting.
- 5.) Compliance will be met on or before August 9, 2021.

K321

- 1.) Maintenance Director or designee will install a closure for the storage area cited. Part ordered to complete project 7/2/21 and is set to arrive 7/7/21.
- 2.) Maintenance Director completed an initial audit on 7/1/21 to determine if compliance is met in all other areas of the facility related to this deficiency including:

- a.) Door closures are present in all appropriate areas
- b.) UL frame ratings are present in all appropriate areas

No other issues were identified related to this deficiency.

- 3.) Initial audit will be sufficient to ensure compliance.
- 4.) Results of audit will be reported in facilities August 2021 PI meeting.
- 5.) Compliance will be met on or before August 9, 2021.

K345

- 1.) Maintenance Director or designee obtained a copy of the quarterly water flow alarm testing report that was completed the 3rd and 4th quarter of 2020. 7/2/21
- 2.) Maintenance Director will complete a quarterly audit to ensure that documentation of the quarterly water flow alarm testing report is obtained.
- 3.) Quarterly audit will ensure deficient practice does not recur.
- 4.) Maintenance Director or designee will report audit findings quarterly in the appropriate facility PI meetings for 1 year or until substantial compliance is met.
- 5.) Compliance will be met on or before July 3, 2021.

K353

- 1.) Maintenance Director or designee obtained a copy of the quarterly priming water, low air alarm, and quick opening devices testing report that was completed the 3rd and 4th quarter of 2020. 7/2/21
- 2.) Maintenance Director will complete a quarterly audit to ensure that documentation of the priming water, low air alarm, and quick opening devices testing report is obtained.
- 3.) Quarterly audit will ensure deficient practice does not recur.
- 4.) Maintenance Director or designee will report audit findings quarterly in the appropriate facility PI meetings for 1 year or until substantial compliance is met.
- 5.) Compliance will be met on or before July 3, 2021.

K355

- 1.) The facility cannot retrospectively complete the missed fire extinguisher inspection cited in this deficiency. Call placed to Phoenix Fire to inspect and certify extinguishers.
- 2.) Maintenance Director or designee will complete a monthly audit to ensure all fire extinguisher inspections are completed as required.
- 3.) Written education provided to maintenance assistant regarding the need to complete all fire extinguisher inspections as required.
- 4.) Maintenance Director or designee will complete the audit monthly and will report monthly at the facility PI meeting for a minimum of 90 days or until substantial compliance is met.
- 5.) Compliance will be met on or before August 9, 2021.

K511

- 1.) Maintenance Director appropriately cover exposed junction box on 7/1/21.
- 2.) Maintenance Director conducted an initial visual audit of the facility to ensure no other junction boxes are exposed 7/1/21.
- 3.) Maintenance Director or designee will conduct a monthly visual inspection to ensure junction boxes are appropriately covered.
- 4.) Audit will be completed monthly and reported monthly in facility PI meeting for at least 90 days or until substantial compliance is met.
- 5.) Compliance will be met on or before July 3, 2021.

K712

- 1.) Facility cannot retrospectively complete the missed fire drill.
- 2.) All other fire drills were completed as required.
- 3.) Cannot provide a corrective action related to this deficiency as the maintenance director at that time is no longer employed by Life Care Center of Casper.
- 4.) Maintenance Director or designee will complete a monthly audit to ensure that all fire drills are completed as directed. Results of the audit will be reported monthly in the facilities PI meeting for at least 90 days or until substantial compliance is met.
- 5.) Compliance will be met on or before July 3, 2021.

K751

- 1.) Maintenance Director or Executive Director will attempt to locate the paperwork to satisfy the requirements of NFPA 701. In the event the paperwork is not located, the facility will replace all curtains and obtain current paperwork to satisfy this requirement.
- 2.) All of the curtains in the facility state "permanently flame retardant" and are lacking the appropriate paperwork to meet criteria NFPA 701.
- 3.) Facility will ensure all curtains in the facility will meet NFPA 701 requirements.
- 4.) Results will be reported in the August 2021 facility PI meeting.
- 5.) Compliance will be met on or before August 9, 2021.

K923

- 1.) Maintenance Director or Designee will ensure installation of mechanical ventilation in the liquid oxygen storage room. Modern Electric is currently working on a bid for this project.
- 2.) This deficiency is not applicable to other areas of the facility.
- 3.) Installation of the system will ensure deficiency will not recur.
- 4.) Maintenance Director or Designee will report completion of project in August 2021 PI meeting.
- 5.) Compliance will be met on or before August 9, 2021.