STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**06/14/2022**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 06/14/2022.	E 000		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:	E 031		7/13/22

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

Electronically Signed | 07/03/2022

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E 031	Continued From page 1 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. Document review on 06/14/2022 at 10:45 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: The State Licensing and Certification Agency, and the Office of the State Long-Term Care Ombudsman. Interview with the facility administrator and facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency.	E 031	E031 Correction: Contact information for the State Licensing and certification agency and the Office of the State Long Term Ombudsman was added to the facility emergency preparedness plan by NHA on or before the date of compliance. Identification: Residents who reside at the facility are at potential risk. Systemic Changes: The maintenance supervisor was educated on the regulations by the NHA at time of the survey. Monitoring: NHA/Designee will review the facility emergency preparedness plan monthly for 3 months and quarterly there after for compliance. Non-compliance will be reviewed in QAPI and correction made at that time.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set	E 041		8/31/22

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E 041	Continued From page 2 forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.	E 041		

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E 041	Continued From page 3 *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30,	E 041		

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E 041	Continued From page 4 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. The failure to verify the reliability of emergency fuel systems as required could result in the generator not functioning in an emergency. The deficiency could affect all staff, residents, and visitors of the facility. The findings were: Document review and staff interview on 06/14/2022 revealed that the facility's emergency generator is supplied with natural gas in lieu of diesel fuel for operation. Further review revealed that the facility was not in possession of a letter of reliability from the utility provider as required by NFPA standards. Interview with the facility administrator and facility maintenance manager at the time of the 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 101, Sections 19.5.1, 9.1, 9.1.2,	E 041	E041: correction action: The facility obtained a letter of reliability from the utility provider as required by the NFPA standards on or before the day of compliance. Identification: Residents, staff and visitors at risk. Systemic changes: The maintenance director was educated by the NHA on or before the date of compliance. Monitoring: NHA/Designee will review the compliance of required documentation for 3 months and quarterly once compliance is achieved. Non-compliance will be reviewed in QAPI.	

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E 041	Continued From page 5 and 9.1.3.1 2012 NFPA 99, Section 6.4.1 2010 NFPA 110, Sections 5.1 and 5.1.4	E 041		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 06/14/2022. 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, 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 54 residents.	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2	K 200		8/31/22

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K 200	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain door leaf encroachment within the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain door leaf encroachment as required could result in the delay of occupant egress during an emergency, which could result in injury or death. The deficiency affected all doors opening to the corridor throughout the facility. The findings were: Observation on 06/14/2022 starting at 8:48 AM, and throughout the survey, revealed that doors used to access storage closets and other rooms with doors opening into the corridor would not swing to the full-open position, and could impede the required width of the means of egress. Observations included the soiled utility closet located near the smoke compartment door at the Birch Wing, which impacted the corridor handrail, and opened to approximately 18 inches from the wall in the full-open position. Additional observations included the Birch Wing storage closet directly across the corridor from the soiled utility room, the Pine Wing storage closet adjacent to the smoke compartment doors, and the Oak Wing storage room adjacent to patient room 252. Interview with the facility maintenance manager at the time of each observation acknowledged each deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiencies.	K 200	K200: Correction Action: Door leaf encroachments will be installed by maintenance on or before the day of compliance on the doors used to access storage closets and other rooms opening into the corridor. The soiled utility closet located near the smoke compartment door at the Birch Wing and Birch Wing storage closet directly across the corridor from the soiled utility room, two Pine Wing storage closet adjacent to the smoke compartment doors, and the Oak Wing storage room adjacent to the patient room 252 have been corrected by maintenance. Identification: Residents who reside at the facility are at risk. Monitoring: Maintenance/Designee will audit facility door leaf encroachment monthly for 3 months and then quarterly once compliance is achieved. Any non-compliance will be reviewed in QAPI.	

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K 200	Continued From page 7 REF: 2012 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.4.3.1	K 200		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress could hinder egress during an emergency, which could lead to injury or death in the event of an emergency. The deficiency affected one (1) of multiple corridors utilized by patients, staff, and visitors. The findings were: Observation on 6/14/2022 at 9:28 AM in the Pine Wing revealed patient lift equipment parked in the corridor, which was not in use. Non-emergency medical equipment shall be permitted to be temporarily located within the means of egress if it is in use, does not reduce the egress width to less than 60 inches, and relocation of the equipment is included in the facility's fire safety and training program. Interview with the facility maintenance manager at	K 232	K232: Corrective Action: Lift equipment parked in Pine Wing was removed on 6/14/2022 by Maintenance Staff. Identification: Residents who reside at facility are at risk. Systemic Changes: Facility staff will be educated on or before the date of compliance by the NHA/Designee Monitoring: NHA/Designee will complete walking rounds weekly for 3 months and then monthly thereafter one compliance is achieved. Observations of noncompliance with result in ad hoc education for the involved staff. Such education will be documented and reviewed at QAPI.	7/13/22

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K 232	Continued From page 8 the time of the 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 19.2.3.4.	K 232		
K 293 SS=E	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 provide exit signs within a means of egress in accordance with the 2012 NFPA 101, Life Safety Code. The failure to adequately identify and mark a means of egress could result in confusion during an emergency, delaying egress from the space, which could result in injury or death. The deficiency affected three (3) of numerous means of egress throughout the facility. The findings were: Observation on 06/14/2022 starting at 8:44 AM in the S. Birch Wing looking north towards the front entrance revealed that no exit sign was visible to identify the means of egress. The only identified means of egress was an exit sign located at the	K 293	K293 Correction: An Exit sign was placed by maintenance in the S. Birch Wing looking North towards the front entrance and the Aspen Wind on or before the date of compliance. Identification: Residents, Staff and visitors are at potential risk. Systemic Changes: NHA/Designee educated the Maintenance Director and assistant on the regulation. Monitoring: NHA/Designee will observe each exit weekly for 1 month and quarterly there after when compliance is achieved. Any non-compliance will be corrected at time of observation and documented on monitoring sheet. Any non-compliance will	8/31/22

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K 293	Continued From page 9 end of the wing at the exterior door. Similar conditions were identified in the Aspen Wing looking east from the entrance, and the Oak Wing looking east while standing at the exterior exit. Interview with the facility maintenance manager at the time of each observation acknowledged each deficiency, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. REF: 2012 NFPA 101, Sections 19.2.1 and 7.10.1.2.1	K 293	be brought to QAPI.	
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	K 321		8/31/22

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K 321	Continued From page 10 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: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain hazardous areas as required could result in injury or death due to fire spread. The deficiency affected five (5) of numerous hazardous areas in the facility. The findings were: 1). Observation on 06/14/2022 at 9:05 AM at the dry storage room near the kitchen revealed that the self-closing device at the door had been disconnected. 2). Observation on 06/14/2022 starting at 9:37 AM in the Spruce Wing revealed several resident rooms that were being utilized for storage of large amounts of combustible materials. The rooms were provided with sprinkler coverage, but the doors were not provided with a self- or automatic-closing device. These conditions were observed in resident rooms 42, 43, 44, and 46. Interview with the facility maintenance manager at the time of each observation acknowledged the deficiencies, and indicated he was unaware of the requirement.	K 321	K321 Correction: A self-closing device at the following doors have been connected by Maintenance before date of compliance, dry storage near the kitchen, rooms 42, 43, 44 and 46. Identification: Residents at facility are at potential risk. Systemic Changes: The maintenance department was educated by the NHA of the regulations. Monitoring: The NHA/Designee will observe door closer monthly for 3 months and quarterly thereafter for compliance, any noncompliance will be reviewed in QAPI.	

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K 321	Continued From page 11 Interview with the facility administrator at the time of exit acknowledged the deficiencies. REF: 2012 NFPA 101, Sections 19.3.2.1 and 19.3.2.1.3.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 324	K324: Corrective Action: Wheel locks for	8/31/22

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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 324	Continued From page 12 facility failed to protect cooking equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were: Observation on 06/14/2022 at 9:14 AM in the kitchen revealed a wheeled gas-fired cooktop located beneath the grease hood and fire suppression system. Further observation revealed that no means was provided to ensure that the cooktop is returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Interview with the facility maintenance manager at the time of the 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 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K 324	the wheeled gas-fire cooktop located beneath the grease hood and shield compression system will be placed by maintenance on or before the date of compliance. Proper floor placement markings and a device to secure the stove will also be place by maintenance on or before the date of compliance. Identification: Resident who reside at facility are at potential risk. Systemic Changes: The maintenance department will be educated by the NHA/Designee on or before the date of compliance. Monitoring: Maintenance/Designee will observe the wheellocks on the moveable stove monthly for 3 months and quarterly thereafter once compliance is achieved. Any noncompliance will be reviewed in QAPI.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as	K 331		8/31/22

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K 331	Continued From page 13 fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to install and maintain interior wall finishes in accordance with the 2012 NFPA 101, Life Safety Code. Failure to install and maintain interior finish materials may lead to an increased risk of fire and smoke spread, resulting in injury or death during an emergency. The deficiency was located in all corridors throughout the facility, and could impact all residents, staff, and visitors. The finding were: Observation on 06/14/2022 starting at 8:45 AM, and continuing throughout the survey, revealed that the facility was in the process of installing new wainscoting throughout all corridors throughout the facility. Observation in the Spruce Hall, where work was not yet complete, allowed the surveyor to determine that the new wainscoting was of solid wood construction with a painted surface, and had been installed directly over existing carpet wainscoting that was original to the facility. Interview with the facility maintenance manager at the time of the observation revealed that no flame and smoke spread testing documentation was available for the material in an assembly as installed. Therefore, it could not be established that the material had been tested and installed in accordance with the Life Safety Code.	K 331	K331: Proper documentation to establish material has flame and smoke spread testing will be provided by contractor on or before the date of compliance. Option two: Facility will install material that has flame and smoke spread testing on walls in corridor. Identification: Residents who reside at facility are at potential risk. Systemic Changes: The Maintenance Director/designee will be educated by NHA/Designee on or before the date of compliance. Monitoring: Maintenance/Designee will verify all new installation of wainscoting to ensure compliance. Any non-compliance will be corrected and brought to QAPI.	

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K 331	Continued From page 14 Measurement of the wainscoting material revealed a height of 44 inches as compared to an overall wall height of 95 inches. As such, the material exceeded the maximum allowable ten percent allowance for incidental finishes per Life Safety Code Section 10.2.5.1, requiring it to be reviewed as an interior wall finish. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency, and also revealed that the renovation project had not been submitted to the State Agency for review and approval in accordance with Life Safety Code requirements. REF: 2012 NFPA 101, Sections 19.3.3.1; 10.2; 10.2.1.1; 10.2.3.	K 331		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		8/31/22

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K 351	Continued From page 15 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide sprinkler systems in accordance with the NFPA 101, Life Safety Code, and 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to provide sprinkler systems as required could result in an increased risk of fire, resulting in injury or death during an emergency. The deficiency affected one (1) of multiple canopies at the facility, and the attic area of the facility. The findings were: 1). Observation on 06/14/2022 at 9:47 AM of the canopy located at the rear of the building, outside the exit adjacent to the laundry, revealed that the canopy was not provided with sprinkler protection, but was constructed of non-combustible materials. Further observation revealed large quantities of combustible materials stored under the canopy. Canopies over areas used for the storage of combustible materials must be provided with sprinkler coverage. Interview with the facility maintenance manager at the time of the 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 19.3.5.1 and 9.7	K 351	K351 Correction: The items under the outdoor canopies were removed by Maintenance on or below the date of compliance. The unattached insulation located within the the attic will be reattached on or before date of compliance. Identification: Residents who reside and facility are at potential risk. Systemic Changes: The Maintenance Director, Maintenance Assistant, Housekeeping Supervisor and Central Supply Coordinator will be educated by the NHA/Designee on or before the date of compliance. Monitoring: NHA/Designee will perform walking rounds to ensure compliance weekly for 3 months and quarterly thereafter once compliance is achieved. Any noncompliance will be brought to QAPI.	

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K 351	Continued From page 16 2010 NFPA 13, Section 8.15.7.5 2). Observation on 06/14/2022 at 9:08 AM of the attic area, via an access panel located within the IT room, revealed that large quantities of roof insulation has become unattached from the underside of the roof, and have fallen to the upper side of the ceiling. In many instances, this insulation has fallen on, or adjacent to, sprinkler heads throughout the attic. This condition may prevent activation of the sprinkler system due to a lack of heat reaching the sprinkler head, and will obstruct the flow pattern of the sprinkler. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the condition and requirements. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.5.1 and 9.7 2010 NFPA 13, Section 8.5.5	K 351		
K 355 SS=F	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 document review and staff interview, the facility failed to test and inspect portable fire extinguishers in accordance with the 2012 NFPA	K 355	K355: Correction: The fire extinguishers through out the facility were tested on or before the date of compliance by a Fire	7/31/22

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K 355	Continued From page 17 101, Life Safety Code, and the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to properly test and inspect portable fire extinguishers could result in injury or death in the event of a fire emergency. The deficiency affected all portable fire extinguishers throughout the facility. The findings were: Document review on 06/14/2022 starting at 10:45 AM revealed that no records were available to demonstrate that all required monthly and annual inspections had been performed as required. Review of inspection tags located at each fire extinguisher revealed that monthly inspections had not been performed between the months of 11/2021 and 04/2022. The tags also indicated that the last annual inspection was performed 04/2021. Interview with the facility maintenance manager acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: NFPA 10, Sections 7.2 and 7.3	K 355	Safety Professional. Identification: Residents who reside at the facility are at potential risk. Systemic Changes: The Maintenance Director and Assistant will be educated by the NHA on or before date of compliance. Monitoring: Maintenance/Designee will monitor the fire extinguisher testing monthly for 2 months and quarterly thereafter to ensure compliance. Any noncompliance will be brought to QAPI.	
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	K 511		8/31/22

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K 511	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to maintain gas-fired equipment could lead to system damage and failure, resulting in injuries to staff or residents. The deficiency affected the kitchen, and all staff working within. The findings were: Observation on 06/14/2022 at 9:14 AM in the kitchen revealed a gas-fired cooktop. Further observation revealed that the cooktop was on casters, and was not provided with the required restraint to protect the flexible gas piping when the cooktop is moved for service or cleaning. Interview with the facility maintenance manager at the time of the 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 54, Section 9.6.1.2	K 511	K511:: Corrective Action: Wheel locks for the wheeled gas-fire cooktop located beneath the grease hood and shield compression system will be placed by maintenance on or the date of compliance. A securing device to hold the stove in place and marketing to indicate stove placement will be placed by maintenance one or before the date of compliance. Identification: Resident who reside at facility are at potential risk. Systemic Changes: The maintenance department will be educated by the NHA/Designee on or before the date of compliance. Monitoring: Maintenance/Designee will observe the wheellocks on the moveable stove monthly for 3 months and quarterly thereafter once compliance is achieved. Any noncompliance will be reviewed in QAPI.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC	K 521		8/31/22

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K 521	Continued From page 19 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 test and maintain HVAC systems in accordance with the 2012 NFPA 101, Life Safety Code, 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating systems, and 2010 NFPA 80, Standard for Fire Doors and Other Opening Protective's. Failure to test and maintain HVAC systems as required could lead to a delayed or failed response to smoke and fire events in the facility, resulting in injury or death. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 06/14/2022 starting at 10:45 AM revealed that the facility had no record of inspection, testing, or maintenance of fire dampers throughout the facility. Fire dampers must be inspected, tested, and maintained at least once during a four (4) year period. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 521	K521 Corrective Action: Facility fire dampers were tested on or before the date of compliance by a fire safety professional. Identification: Residents who reside at the facility are at potential risk. Systemic Changes: The Maintenance Director will be educated by the NHA/Designee. Monitoring: Maintenance/Designee will observe the fire dampers monthly for three months and quarterly thereafter once compliance is achieved. Any noncompliance will be reviewed in QAPI	

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K 521	Continued From page 20 REF: 2012 NFPA 101, Section 9.2.1 2012 NFPA 90A; Section 5.4.8.1 2010 NFPA 80, Section 19.4.1	K 521		
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safe smoking areas in accordance with the the 2012 NFPA 101, Life	K 741	F 741: Facility provided ashtrays on or before the date of compliance by the Maintenance Department.	7/31/22

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K 741	Continued From page 21 Safety Code. Failure to provide safe smoking areas may increase the risk of fire, which may result in injury or death. The deficiency had the potential to affect all staff, residents, and visitors utilizing the smoking area, or located directly inside the building in the immediate area. The findings were: Observation on 06/14/2022 at 9:47 AM at the smoking area located outside of the exit door adjacent to the laundry revealed cigarette butts dispersed throughout dried leaves and accumulated drier lint near the dryer discharge vent. It was apparent that staff, visitors, or residents were not utilizing the smoking area ashtrays located a distance from the building, and were instead congregating near the dryer discharge at the side of the building for warmth while smoking. Interview with the facility maintenance manager at the time of the 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 19.7.4	K 741	Identification: Residents who reside at the facility are at potential risk. Systemic Changes: The staff who work at the facility will be educated on or before the date of compliance. Monitoring: The Maintenance Director/Designee will monitor the outdoor areas for compliance weekly for 3 months and monthly thereafter once compliance is achieved. Any noncompliance will be addressed immediately, and staff re-educated at time of observation. All noncompliance will be brought to QAPI.	
K 900 SS=E	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA	K 900		8/31/22

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K 900	Continued From page 22 standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide ventilation for areas storing or transfilling medical gases in accordance with 2012 NFPA 99, Health Care Facilities Code. Failure to maintain medical gas storage and transfilling areas could result in injury or death. The deficiency could affect all staff working within the medical gas storage and transfilling location. The findings were: Observation on 06/14/22 at 9:54 AM in the medical gas storage and transfilling room revealed that the room was provided with a ceiling-mounted exhaust fan, and the window to the space had been left open for ventilation. Per NFPA 99, ventilation must be provided either via natural ventilation including two (2) openings within one foot of the floor and ceiling, or via mechanical ventilation with an inlet drawing from within one foot of the floor. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was 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; 9.3.7.5.2; 9.3.7.5.3	K 900	K900: Correction: A professional contractor will install NFPA 99, Ventilation either via mechanical ventilation including opening within one foot of the floor and ceiling or via mechanical ventilation with an inlet drawing from within one foot of the floor in the oxygen room. Identification: Residents who reside at the facility are at potential risk. Systemic Changes: The Maintenance Director will be educated by NHA/Designee on or before the date of compliance. Monitoring: The Maintenance Director/Designee will monitor the ventilation in the oxygen room monthly for three months and quarterly thereafter once compliance is complete. Any noncompliance will be brought to QAPI.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101	K 911		8/31/22

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K 911	Continued From page 23 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 record review, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. The failure to verify the reliability of emergency fuel systems as required could result in the generator not functioning in an emergency. The deficiency could affect all staff, residents, and visitors throughout the facility. The findings were: Document review and staff interview on 06/14/2022 revealed that the facility's emergency generator is supplied with natural gas in lieu of diesel fuel for operation. Further review revealed that the facility was not in possession of a letter of reliability from the utility provider as required by NFPA standards. Interview with the facility administrator and facility maintenance manager 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 101, Sections 19.5.1, 9.1, 9.1.2,	K 911	K911: Corrective Action: The facility obtained a letter of reliability from the utility provider as required by the NFPA standards on or before the day of compliance. Identification: Residents, staff and visitors at risk. Systemic changes: The maintenance director was educated by the NHA on or before the date of compliance. Monitoring: NHA/Designee will review the compliance of required documentation for 3 months and quarterly once compliance is achieved. Non-compliance will be reviewed in QAPI.	

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(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 24 and 9.1.3.1 2012 NFPA 99, Section 6.4.1 2010 NFPA 110, Sections 5.1 and 5.1.4	K 911		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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	K 923		8/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**06/14/2022**

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K 923	Continued From page 25 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: Based on Observation and staff interview, the facility failed to maintain areas for storage of positive pressure gases in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain areas for storage of positive pressure gases could result in injury or death in an emergency. The deficiency could affect all staff, residents, or visitors within the vicinity of the space due to an increased risk of fire spread. The findings were: Observation on 06/14/22 at 9:54 AM in the medical gas storage and transfilling room revealed that the space contained ten (10) 40 L liquid O2 dewars, and six (6) 15 cu. ft. cylinders. Additionally, it was observed that the space was provided with a 90 minute fire-rated door, but it could not be established that the wall construction of the space provided the required 1-hr fire resistance rating. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. It was also acknowledged that this area has been cited repeatedly in the past, and that the facility has relocated gas storage in smaller volumes throughout the facility for compliance with NFPA 99. It was acknowledged that the facility has	K 923	K923: Corrective Action: Facility continues to work with Architect and State of Wyoming to establish that the wall construction of the oxygen room provides the required 1-hr fire resistance rating. HLS Project # - 2021-065 Identification: Residents who reside at the facility are at risk. Systemic Changes: The NHA/Designee educated the maintenance department on or before the date of compliance on the regulation Monitoring: The Maintenance Director/Designee will monitor the oxygen room required 1-hr rating monthly for 3 months until compliance is achieved. Any noncompliance will be brought to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 923	Continued From page 26 repeatedly reverted to again storing larger quantities of oxygen within the observed space upon completion of the survey cycle. REF: NFPA 99, Section 5.1.3.3.2 (4), (7)	K 923		