

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

PRINTED: 09/27/2022
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 07/26/2022	
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			E 000			
E 031 SS=F	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 07/26/2022. 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			9/21/22

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

TITLE

(X6) DATE

Electronically Signed

08/19/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 09/27/2022
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 07/26/2022
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 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 07/26/2022 at 11:15 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: Federal, State, tribal, regional, or local emergency preparedness staff. Interview with the maintenance assistant at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency.	E 031	IDR Attached: 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 the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of the state and federal law. For the purposes of any allegations that the facility is not in substantial compliance with federal requirement for participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. 1. Problem Statement: Facility failed to develop and maintain emergency preparedness contact information in accordance with 483.73(c). 2. Corrective Action: - In-service - education provided to the maintenance assistant and maintenance Director on 8/18/2022. 3. Identification of others: - Failure to develop and maintain the		

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

PRINTED: 09/27/2022
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 07/26/2022
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 031	Continued From page 2	E 031	emergency preparedness contact information could result in the supervising agency not being notified in an emergency. 4. Systemic changes: - Facility in compliance with 483.73(c) as of 7/28/2022 ensuring that contact list in the emergency preparedness plan was had updated information for: Federal, State, tribal, regional, or local emergency preparedness staff. 5. Ongoing Monitoring: - Maintenance Director/ Designee will ensure that contact list in the emergency preparedness plan continues to be updated with: Federal, State, tribal, regional, or local emergency preparedness staff. Ensuring compliance with 483.73(c).		
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 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.	E 041			9/21/22

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

PRINTED: 09/27/2022
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 07/26/2022
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 041	Continued From page 3 §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. *[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	E 041			

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

PRINTED: 09/27/2022
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 07/26/2022
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 041	Continued From page 4 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, 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 and staff interview,	E 041	1. Problem Statement:		

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

PRINTED: 09/27/2022
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 07/26/2022
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 041	Continued From page 5 the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview on 07/26/2022 at 9:45 AM revealed that no record of monthly generator battery specific gravity or conductance tests was available. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1.1, 9.1, 9.1.3.1 2010 NFPA 110, Sections 8.2.4, 8.2.4.1, 8.3.7.1	E 041	Facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery testing tests as required. 2. Corrective Action: - In-service - education provided to the maintenance assistant and maintenance Director on 8/18/2022. 3. Identification of others: - The deficiency affected facility-wide reliability of the emergency power system. 4. Systemic changes: - Maintenance will get equipment needed to do battery specific gravity on conductive test on battery and will document on TELS monthly. This equipment will be purchased by 8/31/2022. 5. Ongoing Monitoring: - The maintenance director will ensure the monthly generator tests are completed and in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. - Audits of TELS will be brought to monthly QAPI Meeting, reviewed and continue until QAPI team determines sustained compliance.		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 07/25/2022	K 000			

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

PRINTED: 09/27/2022
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 07/26/2022
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 000	Continued From page 6 and 07/26/2022. 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, single story building of Type V (111) construction built 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 86 residents.	K 000			
K 211 SS=D	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 observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous exits. The findings were:	K 211	1. Problem Statement: Facility failed to maintain means of egress in accordance with the 2012 NFPA 101. At the dining room exit to building front revealed that the means of egress, 1 door exit, was obstructed by exterior furniture. It was further noted that the chair that was in the egress pathway prevented the exit door from fully opening	9/21/22	

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

PRINTED: 09/27/2022
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 07/26/2022
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 211	Continued From page 7 Observation on 07/25/22 at 4:42 PM at the dining room exit to building front revealed that the means of egress was obstructed by exterior furniture. It was further noted that the chair that was in the egress pathway prevented the exit door from fully opening. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.3.1; 7.1.10.1	K 211	2. Corrective Action: • In-service - education provided to the maintenance assistant and maintenance Director on 8/18/2022. 3. Identification of others: • Failure to maintain means of egress as required could delay egress. 4. Systemic changes: • The chair has been removed and the door now in accordance with 2012 NFPA 101. 5. Ongoing Monitoring: • The maintenance director will assign daily tasks on TELS for obstructions to be moved from Aisles, passageways, corridors, exit discharges, exit locations, and accesses in accordance with Chapter 7. • Audits of TELS will be brought to monthly QAPI Meeting, reviewed and continue until QAPI team determines sustained compliance		
K 222 SS=D	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	K 222			9/21/22

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

PRINTED: 09/27/2022
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 07/26/2022
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 222	Continued From page 8 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 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.	K 222			

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

PRINTED: 09/27/2022
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 07/26/2022
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 222	Continued From page 9 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 provide a delayed egress door that operated in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a delayed egress door that functioned as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous doors in the facility. The findings were: Observation on 07/25/2022 at 4:15 PM at the employee entrance, revealed that the door was equipped with a sign indicating that the door was equipped with a delayed egress system. When force was applied to the door hardware no sound was emitted after the listed amount of time and the door did not open. It appeared that the door would only open when a code (which was posted at the door) was input into a number pad at the door. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Director of Nursing at the time	K 222	1. Problem Statement: Facility failed to provide a delayed egress door that operated in accordance with the 2012 NFPA 101, Life Safety Code. 2. Corrective Action: • In-service - education provided to the maintenance assistant and maintenance Director on 8/18/2022. 3. Identification of others: • Failure to provide delayed egress door that functioned as required could delay egress. 4. Systemic changes: • Employee Entrance signage had been placed on door by maintenance assistant. Signage was removed during survey by maintenance director. No need for Emergency Egress. Maintenance director will ensure delayed egress door is operating in accordance to 2012 NFPA 101, and life safety code and to determine the process in place is effective. 5. Ongoing Monitoring:		

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

PRINTED: 09/27/2022
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 07/26/2022
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 222	Continued From page 10 of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.8.2	K 222	Maintenance Director will put monthly task in TELS to have maintenance team look at egress doors for signage. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.	9/21/22	
K 223 SS=E	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 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: 1. Based on observation and staff interview, the facility failed to maintain self-closing corridor doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain self-closing corridor doors as required could delay egress or prevent egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous self-closing doors in the facility. The findings were: Observation on 07/25/2022 at 2:28 PM in the physical therapy room found that the door to the	K 223			

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

PRINTED: 09/27/2022
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 07/26/2022
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 11 corridor, which was equipped with an approved hold open device, was prevented from being able to close and latch by a resident receiving care. The bed for physical therapy was arranged in such a manner that the edge of the door nearly aligned with the edge of the bed. Interview with staff found residents receiving care in front of the door to be a common occurrence. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.8.2 2. 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 delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous self-closing doors in the facility. The findings were: Observation on 07/25/2022 at 4:10 PM at the medical records room revealed that the door failed to latch. When tested by being dropped from full open position with no initial motion it was found that the door failed to fully close and latch. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 223	therapy door to the corridor, which was equipped with an approved hold open device, preventing the therapy door to close and latch by resident receiving care. 3. Identification of others: - Failure to provide a latching self-closing door as required could delay egress. 4. Systemic changes: - The bed for physical therapy was rearranged on 8/18/2022 to allow self-closing corridor doors. - Latch is to be fixed in medical records by the end of 8/31/2022 by Maintenance Director 5. Ongoing Monitoring: - Maintenance Director will put monthly task in TELS to maintenance team look at self-closing corridor doors in therapy and the latch in medical records. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		

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

PRINTED: 09/27/2022
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 07/26/2022
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 12 Interview with the Director of Nursing at the time of exit acknowledged the deficiency.	K 223			
K 324 SS=D	REF: 2012 NFPA 101: Section 7.2.1.8.2 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 facility failed to protect cooking equipment in	K 324			9/21/22
			1. Problem Statement: Facility failed to protect cooking equipment in accordance		

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

PRINTED: 09/27/2022
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 07/26/2022
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 324	Continued From page 13 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 07/25/2022 at 4:34 PM 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 maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the Director of Nursing 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	with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, standard for ventilation control and fire protections of commercial cooking operations. 2. Corrective Action: - In-service education for maintenance and dietary staff completed by 8/31/2022. 3. Identification of others: - Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems. 4. Systemic changes: - Maintenance has marked the floor for the proper alignments with the arousal system and will continue to watch the placement of the stove and make sure area is properly marked to be in compliance with 2012 NFPA 101 Life Safety code, and the 2011 NFPA 96, standard for ventilation control and fire protections of commercial cooking operations. 5. Ongoing Monitoring: - Maintenance Director will put monthly task in TELS to monitor placement of the cooktop beneath the fire suppression systems after being moved for service or cleaning. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		9/21/22	

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

PRINTED: 09/27/2022
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 07/26/2022
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 14 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 observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected all storage rooms throughout the facility. The findings were: Observation on 07/25/2022 at 3:47 PM in the activity's storage revealed exercise balls stacked to a height above the sprinkler head. Numerous storage locations in the building were found to have storage stacked to within eighteen (18) inches of the sprinkler head.	K 353	1. Problem Statement: Facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. 2. Corrective Action: - In-service education for maintenance completed by 8/18/2022. - Maintenance Director/Designee will educate staff by 8/31/2022 in the areas of storage about the requirements of height from sprinkler heads and also help by marking the height on the walls with colored tap to help ensure compliance with 2012 NFPA 101, Sections: 19.3.5.1;		

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

PRINTED: 09/27/2022
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 07/26/2022
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 15 Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 353	9.7.5 2011 NFPA 25, Section 5.2.1.2. 3. Identification of others: • The failure to maintain sprinkler systems as required in accordance to 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2. could lead to equipment damage or improper protection by fire suppression systems. 4. Systemic changes: • Maintenance will mark all storage rooms by 8/31/2022 with colored tap to ensure compliance with 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2. 5. Ongoing Monitoring: • Maintenance Director will put monthly task in TELS to monitor placement of storage from the sprinkler systems. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		
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 maintain fire extinguishers in accordance with the 2010 NFPA 10, Standard for	K 355	1. Problem Statement: Facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code	9/21/22	

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

PRINTED: 09/27/2022
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 07/26/2022
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 16 Portable Fire Extinguishers and the 2012 NFPA 101, Life Safety Code. Failure to maintain fire extinguishers as required may lead to injury or death during an emergency. The deficiency affected one (1) of numerous fire extinguishers in the facility. The findings were: Observation on 07/25/2022 at 3:10 PM revealed a fire extinguisher adjacent to room 107 that was found to be missing the June signoff. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 6.1.3.3.1	K 355	and the 2011 NFPA 25, standard for the inspection, testing and maintenance of water based fire protection systems. 2. Corrective Action: - In-service education for maintenance completed by 8/18/2022. 3. Identification of others: - Failure to maintain fire extinguishers as required by 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 6.1.3.3.1. 4. Systemic changes: - Maintenance director/ designee will inspect fire extinguisher adjacent to room 107 that was found to be missing the June signoff and will complete this task and document by 8/31/2022 to ensure compliance with 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 6.1.3.3.1. 5. Ongoing Monitoring: - Maintenance director/ designee will inspect fire extinguishers monthly and document as required by 2012 NFPA 101: Section 19.3.5.1.2, 9.7.4.1 2010 NFPA 10: Section 6.1.3.3.1. - Maintenance Director will put monthly task in TELS to monitor placement of storage from the sprinkler systems. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101	K 753			9/21/22

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

PRINTED: 09/27/2022
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 07/26/2022
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 753	Continued From page 17 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: - o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. - o Decorations meet NFPA 701. - o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. - o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). - o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to spray combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to spray combustible decorations as required could quickly increase a fire's size in the building during an emergency resulting in injury or death. The deficiency affected numerous rooms in the building. The findings were: Observation on 07/25/2021 at 3:56 PM in resident room 122 revealed a large flag approximately five (5) feet long by three (3) feet tall, hanging above a resident bed. No tag was placed on the flag to state when, or if, it was provided with a fire-retardant treatment. In reviewing records it was observed that no records were available to demonstrate application of fire-retardant coatings to staff or resident provided decorations. Several other large decorations (such as wreaths) were	K 753	1. Problem Statement: Facility failed to spray combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. 2. Corrective Action: • All staff in-service education completed by 8/31/2022 regarding deficiency. 3. Identification of others: • Failure to spray combustible decorations as required could quickly increase a fire's size in the building during an emergency. 4. Systemic changes: • Maintenance Director/ designee will ensure tag with date and fire-retardant		

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

PRINTED: 09/27/2022
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 07/26/2022
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 753	Continued From page 18 observed in other resident rooms and offices. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.5.1, 19.7.5.6, 10.3.1	K 753	treatment are on the large flag approximately five (5) feet long by three (3) feet tall, hanging above the bed of resident room 122 by 8/31/2022 to be in compliance with 2012 NFPA 101 sections: 19.7.5.1, 19.7.5.6, 10.3.1. 5. Ongoing Monitoring: • Maintenance Director/Designee will ensure that a tag is placed on resident objects/ staff objects that need fire-retardant treatment and when the treatment was provided. • Maintenance Director will put monthly task in TELS to monitor objects that are needing to be tagged, dated, and sprayed with fire-retardant. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. The failure to provide portable space heaters as required could result in injury or death due to an increased risk of fire. The deficiency	K 781	1. Problem Statement: Facility failed to not use portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. 2. Corrective Action:		9/21/22

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

PRINTED: 09/27/2022
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 07/26/2022
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 781	Continued From page 19 affected one (1) of multiple rooms in the facility. The findings were: Observation on 07/25/2022 at 2:50 PM in the Unit 2 Manager office revealed a portable space heater. The area is a non-sleeping staff area, however no documentation was available to determine the maximum temperature of the heating elements. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 19.7.8	K 781	- All staff in-service education completed by 8/31/2022 regarding tag. 3. Identification of others: - Failure to not use portable space heaters could resolve in increased risk of fire as required by 2012 NFPA 101, Section 19.7.8. 4. Systemic changes: - Unit 2 manager office portable space heater removed during survey by maintenance director. - Portable space heaters were removed from the facility and staff have been educated about the heaters not being used in the building to ensure compliance with 2012 NFPA 101, Section 19.7.8. 5. Ongoing Monitoring: - Maintenance Director will put monthly task in TELS to monitor the use of space heaters and make sure that the space heaters are not in the building. Audits will be brought to monthly QAPI meeting, reviewed, and continued until QAPI team determined sustained compliance.		
K 918 SS=D	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		9/21/22	

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

PRINTED: 09/27/2022
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 07/26/2022
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 918	Continued From page 20 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency affected facility-wide reliability of the emergency power system. The findings were: Document review and interview on 07/26/22 at	K 918	1. Problem Statement: Facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery testing tests as required. 2. Corrective Action: In-service - education provided to the maintenance assistant and maintenance Director on 8/18/2022.		

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

PRINTED: 09/27/2022
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 07/26/2022
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 918	Continued From page 21 9:45 AM revealed that no record of monthly generator battery specific gravity or conductance tests was available. Interview with the maintenance assistant at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1.1, 9.1, 9.1.3.1 2010 NFPA 110, Sections 8.2.4, 8.2.4.1, 8.3.7.1	K 918	3. Identification of others: - The deficiency affected facility-wide reliability of the emergency power system. 4. Systemic changes: - Maintenance will get equipment needed to do battery specific gravity on conductive test on battery and will document on TELS monthly. This equipment will be purchased by 8/31/2022. 5. Ongoing Monitoring: The maintenance director will ensure the monthly generator tests are completed timely and will ensure compliance with 2010 NFPA 72 Table 14.4.5(20), Figure 14.6.2.4 page 11.		