

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

PRINTED: 05/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 05/10/2023	
NAME OF PROVIDER OR SUPPLIER CASPER MOUNTAIN REHABILITATION AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4305 S POPLAR 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}			
	An Emergency Preparedness revisit survey was conducted by Healthcare Licensing and Surveys on 05/10/2023 for deficiencies identified on 03/21/2023. All deficiencies have been corrected, and the facility is now back in compliance with 42 CFR 483.73.						
{K 000}	INITIAL COMMENTS			{K 000}			
	A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 05/10/2023.						
	Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association.						
	The facility was a fully sprinklered single story building of Type V (111) construction with plan approval in 1967 and 1973. The building was equipped with a supervised wet sprinkler system with anti-freeze branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 93 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.						
{K 223} SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101			{K 223}			5/10/23
	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						

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

TITLE

(X6) DATE

Electronically Signed

05/18/2023

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

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{K 223}	Continued From page 1 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching and self-closing door 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 05/10/2023 at 9:38 AM of the house keeping storage door revealed that the door was equipped with a self-closing device, but failed to latch when dropped with no initial motion. Interview with the facility maintenance at the time of 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. REF: 2012 NFPA 101: Section 7.2.1.8.2	{K 223}	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 SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified in this		

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{K 223}	Continued From page 2	{K 223}	deficient practice. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the potential to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The self-closure was readjusted along with adjustment made to the door lock/latch to ensure proper closure. All doors with self-closures will be checked weekly to ensure proper operation by the Maintenance director/designee. The Maintenance Director was educated by the NHA to ensure doors with self-closing devices latch properly. The Maintenance Director/Designee will update facility "TELS" program to include weekly task of doors with self-closures. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved.		

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