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 _____	**08/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**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 08/02/2023. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 08/02/2023. 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, 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 56 residents. The following deficiencies demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 211 SS=E	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	K 211		9/11/23

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

Electronically Signed | 08/18/2023

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 211	Continued From page 1 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 provide stairways and handrails in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain stairs and handrails as required could result in a fall hazard, which may result in injury or death. The deficiencies affected all egress stairwells at the south facing side of the building, and could impact all residents, staff, or visitors utilizing these egress paths. The findings were: 1. Observation on 08/02/2023 starting at 10:40 AM at the south facade of the building revealed multiple stairwells used as a means of egress for individual nursing wings. Additional observation revealed that the stairwells ranged in width from 6'-10" to 7'-2", and were provided only with handrails on each side, and did not include an additional intermediate handrail to ensure that handrails are provided within 44 inches of all portions of the egress width. 2. Observation on 08/02/2023 starting at 10:40 AM of the western stairwell at the south facade of the building revealed that the upper tread of the concrete stairwell had been damaged, and was missing a portion of approximately 6 inches in width. The change in surface slope and elevation could result in a slipping hazard when utilizing the stairs. Interview with the facility maintenance maintenance manager at the time of the observations acknowledged the deficiencies, and indicated he was not aware of the requirement.	K 211	K-211 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 7305 of the state operations manual. Corrective Action: 1. Add an additional intermediate handrail down the center of the stairwells to ensure that handrails are provided within 44 inches of all portions of egress width in accordance with 2012 NFPA 101, Sections 19.1 7.2.2.4.1.2(2), and 7.2.2.3.3.2 2. The upper tread of the concrete stairwell has been repaired. ID of Others: The building was inspected for other stairwells needing a center rail or repair of missing concrete	

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K 211	Continued From page 2 Interview with the facility administrator at the time of exit acknowledged the deficiencies. REF: 2012 NFPA 101, Sections 19.1, 7.2.2.4.1.2(2), and 7.2.2.3.3.2	K 211	Systemic Changes: 3 stairwells will be repaired to meet 2012 NFPA 101, Sections 19.1, 7.2.2.4.1.2(2), and 7.2.2.3.3.2 on or before 09/11/2023 The upper tread of the concrete stairwell will be repaired 09/11/2023 Also entered in the TELs program with inspection of the existing stairwells Monitor: Observations of these items will be monitored on weekly walking rounds by Maintenance Director/Designee for 2 months and then Quarterly in conjunction with TELS System and then as needed to identify any concerns regarding compliance. The NHA/Designee will monitor the results in QAPI committee meeting for 3 months then as needed to ensure compliance. Date of Compliance: 09/11/2023	
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		8/24/23

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K 222	Continued From page 3 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		

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K 222	Continued From page 4 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 egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide egress door as required could result in delayed egress from the facility during an emergency, which may result in injury or death. The deficiency could impact all residents, staff, or visitors attempting to utilize the exits. The finding were: 1. Observation on 08/02/2023 at 11:12 AM at the exterior exit adjacent to resident room 106 revealed that the door was provided with a delayed egress system. Attempts to activate the delayed egress system revealed that the system would not enter an irreversible process that released the lock in the direction of egress without applying a force in excess of 15 lbf. 2. Observation on 08/02/2023 at 11:30 AM at exterior egress door number 8 revealed that the door was provided with a delayed egress system, but the door was not provided with the required signage. Interview with the facility maintenance manager at the time of each observation acknowledged the	K 222	K- 222 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 the provisions of federal and state law require it. 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 7305 of the state operations manual. Corrective Action: 1. The delayed egress system door adjacent to resident room 106 was adjusted to release the lock in the direction of egress with applying minimal force of 15# or less within 15 seconds. 2. Required Signage was added to door	

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K 222	Continued From page 5 deficiencies, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged each deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.4, 19.2.2.2.5, and 7.2.1.6.1	K 222	#8. ID of Others: All doors with delayed egress system in place have been inspected to ensure they all had signage and were working within the code of 2012 NFPA 101, Sections 19.2.2.2.4, 19.2.2.2.5, and 7.2.1.6.1 Systemic Changes: All doors with delayed egress system locks will be added to the TELS system to be monitored to ensure compliance. Monitor: Observations of these delayed egress system locks will be monitored on weekly walking rounds by Maintenance Director/Designee for 2 months and then Quarterly in conjunction with TELS System and then as needed to identify any concerns regarding proper functioning. The NHA/Designee will monitor the results in QAPI committee meeting for 3 months then as needed to ensure compliance. Date of Compliance: 08/24/2023	
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	K 321		8/24/23

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K 321	Continued From page 6 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: 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 one (1) of numerous hazardous areas in the facility. The findings were: Observation on 08/02/2023 starting at 10:35 AM at resident room 230 revealed the room was	K 321	K- 321 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 the provisions of federal and state law require it. For the purposes	

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K 321	Continued From page 7 being utilized for storage of large amounts of combustible materials. The room was provided with sprinkler coverage, and the door was provided with a self- or automatic-closing device. However the door failed to fully close when released from the full open position. Interview with the facility maintenance manager at the time of each observation acknowledged the deficiency, and indicated he was aware of the requirement. 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	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 7305 of the state operations manual. Corrective Action: The self automatic closing device was repaired to fully close when released from the full open position. ID of Others: All other doors with automatic-closing devices will be monitored to ensure they are all closing REF: 2012 NFPA 101, Sections 19.3.2.1 and 1 9.3.2.1 .3. Systemic Changes: Maintenance Director/Designee will complete weekly room rounds for 2 months and then Quarterly in conjunction with TELS System and then as needed to identify doors are closing properly. Monitor: Maintenance Director/Designee will complete weekly room rounds for 2 months and then Quarterly in conjunction with TELS System and then as needed to identify doors are closing properly. Date of Compliance: 08/24/2023	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie	K 374		8/24/23

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K 374	Continued From page 8 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors in smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide doors in smoke barriers as required could result in the propogation of smoke, which may hinder egress, and result in injury or death. The deficiency could impact all residents, staff, and visitors within the facility. 1. Observation on 08/02/2023 at 10:10 AM at the smoke compartment door adjacent to resident room 330 revealed that, when released from the fully-open position, the door would not fully close within the door frame, and left a gap of approximately one-half of an inch. 2. Observation on 08/02/2023 starting at 11:25 AM at the smoke compartment doors adjacent to resident room 254 revealed that one leaf of the doors was provided with an astragal. Further	K 374	K- 374 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 the provisions of federal and state law require it. 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 7305 of the state operations manual. Corrective Action: 1.The smoke compartment door adjacent	

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K 374	Continued From page 9 observation revealed that a coordinator was not provided, which allowed the leaf with the astragal to close first, resulting in the second leaf not closing within the door frame. Interview with the facility maintenance manager at the time of the observation revealed that this condition was recurring at multiple locations. Interview with facility maintenance manager at the time of each observation acknowledged the deficiencies, and indicated he was aware of the requirements. Interview with the facility administrator at the time of exit acknowledged each deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.4 and 19.2.2.2.5	K 374	to resident room 330 was adjusted to fully close within the door frame. 2. The smoke compartment doors adjacent to resident room 254 will be adjusted when coordinators that have been ordered arrive and will be installed by Western States Fire Safety. ID of Others: 1.All other smoke compartment doors will be inspected to ensure they fully close within the door frame and no gaps are exposed. 1. All doors with smoke compartment coordinators will be identified and new coordinators will be added by Western State Fire Safety as soon as they come in. Systemic Changes: All Smoke compartment doors will adjust and will be monitored weekly in accordance with TELS through walking rounds by Maintenance Director/designee weekly for 2 months then Quarterly. Monitor: The main Director/designee will monitor weekly in accordance with TELS system through walking rounds, and record into TELS recording system. The NHA/Designee will monitor the results in QAPI monthly committee meeting for 3 months then as needed to ensure compliance. Date of Compliance:	

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K 374	Continued From page 10	K 374	08/24/2023	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 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 limit combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to limit combustible decorations as required could result in an increased risk of fire spread, and could result in injury or death. The deficiency affected one of multiple resident rooms throughout the facility. The findings were: Observation on 08/02/2023 at 10:12 AM in resident room 339 revealed an artificial christmas tree, and a large number of photographs that were backed with construction paper boarders on the residents wall. The photographs covered approximately 50 percent of the wall area.	K 753	K-753 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 the provisions of federal and state law require it. 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	8/24/23

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K 753	Continued From page 11 Additionally, it could not be establish that the artificial christmas has been treated with a fire-retardant coating. 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 101, Section 19.7.5.6	K 753	compliance in accordance with section 7305 of the state operations manual Corrective Action: 1. The artificial Christmas Trees in room were removed. 2. The Photographs that were backed with construction paper boarders on the resides wall were removed. ID of Others: 1. All rooms were checked for artificial Christmas trees. 2. All resident rooms were checked for photographs, flammable paper boarders on resident walls. Corrective Action: 1. Family members of residents who had Christmas Trees bought new Flame-retardant Trees/lights to comply with 2012 NFPA 101 life Safety Code. Personal Pictures on the wall of residents rooms were taken down 1. and some added to frames and others on Digital picture frame. Systemic Changes: On admission, Maintenance/designee will meet with new Residents/Family members to explain combustible Decore in resident rooms. Monitor: Observations of these items will be monitored on weekly walking rounds by Maintenance Director/Designee for 2 months and then Quarterly in conjunction with TELS System and then as needed to identify any concerns regarding combustible decoration/pictures. The	

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 _____	**08/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**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 753	Continued From page 12	K 753	NHA/Designee will monitor the results in QAPI committee meeting for 3 months then as needed to ensure compliance. Date of Compliance: 08/24/2023	