STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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 An Emergency Preparedness revisit survey was performed by Healthcare Licensing and Surveys on 07/08/2024 for all previous deficiencies identified on 06/12/2024. All deficiencies have been corrected, and the facility is now back in compliance.	{E 000}		
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 07/08/2024 for all previous deficiencies identified on 06/12/2024. 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 an 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 76 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90	{K 000}		
{K 345} SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	{K 345}		7/22/24

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

Electronically Signed | 07/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 345}	Continued From page 1 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Document review on 07/08/2024 starting at 1:15 PM revealed that the facility was able to produce documentation demonstrating the Fire Alarm System had been tested within the last 12 months. However, the documentation did not provide a location and pass/fail test for the alarm notification devices as required. Interview with the administrator-in-training at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement. Interview with the administrator-in-training at the time of exit confirmed the deficiency. Ref: NFPA 101, Sec. 19. 3.4.1, 9.6.1.3; NFPA 72, Table 14.4.5	{K 345}	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. Corrective action for Residents affected by the deficient practice- The Fire Alarm System has been tested to provide location and pass/fail test for alarm notification devices as required in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm Code. The test was conducted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 345}	Continued From page 2	{K 345}	on July 11th, 2024 by an outside contractor. How the facility identified other residents with the potential to be affected by the same deficient practice. All residents, staff, and visitors are at risk of being affected by the alleged deficiency. Audit was conducted of the Fire Alarm test results to ensure all alarms passed the test conducted on July 11th, 2024. Audit showed all alarms passed with no deficiencies. Measure or systemic changes made to ensure the deficient practice will not occur again. By 7/12/2024 the Maintenance Director/designee was provided and educated in-service by the NHA/designee to ensure the fire alarm system testing includes location and pass/fail for the alarm notification devices per the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, and National Fire Alarm Code. Maintenance Director/designee will perform monthly audits of all required state life safety annual testing will be conducted x 3 months to ensure compliance. Any identified concerns will be addressed immediately. How the facility plans to monitor performance to make sure the solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 345}	Continued From page 3	{K 345}	The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	
{K 371} SS=D	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in accordance with NFPA101, Life Safety Code. Failure to maintain smoke barriers as required could lead to the propagation of smoke during an emergency leading to injury or death. The deficiency affected one smoke compartment door in the facility. The findings were: Observation on 07/08/2024 at 12:50 PM at the	{K 371}	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	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 371}	Continued From page 4 smoke compartment doors in hall 1 revealed cross-corridor doors that were self-closing or automatic-closing, and held open by magnetic hold-open devices connected to the fire alarm system. When dropped with no initial motion, the doors failed to close completely. This failure was due to the lack of a door closer coordinating device. The lack of a door closer coordinating device allowed the door leaf equipped with an astragal to close first, not allowing a smoke proof seal. Interview with the maintenance personnel at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement. Interview with the administrator-in-training at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sec. 19.3.7.8, 8.5.4	{K 371}	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. Corrective action for Residents affected by the deficient practice- The facility will provide training certification for the Maintenance Director/designee in 2016 NFPA 80 Swinging Fire Door Inspection Training Series. The training was completed on July 8, 2024. The Maintenance Director/designee will repair Hall 1 cross-corridor, smoke compartment doors in accordance with NFPA 101, Life Safety Code. Repairs were made on July 12, 2024. How the facility identified other residents with the potential to be affected by the same deficient practice. All residents, staff, and visitors are at risk of being affected by the alleged deficiency. NHA conducted audit of all fire doors after the repair on July 12, 2024, and found them all to be in working order. Measure or systemic changes made to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 371}	Continued From page 5	{K 371}	ensure the deficient practice will not occur again. By 7/12/2024 the Maintenance Director/designee was provided with education in-service by the NHA/designee to ensure that all smoke compartment doors close completely. On 7/8/2024 the Maintenance Director completed training in the National Fire Protection Association for 2016 NFPA 80 Swinging Door Inspection Training Series with ID # 2144104231 The Maintenance Director/designee will perform weekly audits x 4 weeks, then monthly audits for 2 additional months to ensure compliance. Any concerns will be addressed immediately. How the facility plans to monitor performance to make sure the solutions are sustained. The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	
{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	{K 900}		8/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 900}	Continued From page 6 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 standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain main and feeder circuit breakers in accordance with 2012 NFPA 99, Heath Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency affected the facilities main and backup electric system. The findings were: Document review on 07/08/2024 starting at 1:15 PM revealed the facility was not able to provide documentation demonstrating that the main and feeder circuit breakers had been tested. Interview with the administrator-in-training at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement. Interview with the administrator-in-training at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 Ch.10 Sec. 4.4.1.2	{K 900}	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. Corrective action for Residents affected by the deficient practice- The facility has contacted multiple outside contractors to have their main circuit breaker tested. We found a contractor that states they will come do the test on or before August 5th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	R **07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**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
{K 900}	Continued From page 7	{K 900}	How the facility identified other residents with the potential to be affected by the same deficient practice. All residents, staff, and visitors are at risk of being affected by the alleged deficiency. Measure or systemic changes made to ensure the deficient practice will not occur again. By 7/12/2024 the Maintenance Director/designee was provided an education in-service by NHA/designee to ensure the maintenance team was fully aware of what it would entail to gain compliance in accordance with the 2012 NFPA 99, Health Care Facilities Code. The facility will do a one time audit immediately after the contractor□s testing to ensure the testing was done correctly and that it met CMS standards. How the facility plans to monitor performance to make sure the solutions are sustained. Maintenance Director or Designee will review the results of the test once the test is completed. They will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required	