Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9055	A. BUILDING: _____ B. WING _____	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN PLAZA ASSISTED LIVING	536 EAST 20TH AVENUE TORRINGTON, WY 82240

(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) COMPLETE DATE
S 000	General Comments A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 10/21/2025. The facility was a fully sprinklered single story buildings of Type V (000) construction with a plan approval of 2020. The building was equipped with a supervised wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 45 licensed beds with a census of 34 residents. Wyoming Department of Health Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4, Section 10, Life Safety and Electrical Safety. The requirements in the Department of Health Chapter III, Construction Rules and regulation for Healthcare Facilities applies (II) Assisted Living Facilities in operation prior the effective date of those rules shall meet the Life Safety Code of National Fire Protection Association that was in effect at the time the facility was licensed as an Assisted Living Facility. All references are based on the requirements of NFPA 101, Life Safety Code, New Board and Care 2006 Edition, unless otherwise noted.	S 000		
S8015	NFPA Life Safety - Nfpa Prot from Hazards NFPA 101 Protection from Hazards This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to protect an area having a degree of hazard greater than that normal to the general occupancy of the building or structure in accordance with the 2006 NFPA 101, Life Safety	S8015		

I called Brian Small on 11-19-25 at 9:44 Am and advised him on the acceptance of their P.O.C.

Matt Langley

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S8015	Continued From page 1 Code. Failure to protect hazardous areas could allow for spread of fire or smoke during a fire emergency, resulting in injury or death. The deficiency could affect all staff within the affected smoke compartment. The findings were: Observation on 10/21/2025 at 11:30 AM indicated that the kitchen dry storage room contained hazardous quantities of storage requiring the room to be protected from other areas in accordance with the 2006 NFPA 101, section 8.7. Further observations revealed the storage room was protected with a smoke partition, but the storage room door was not a self-closing or automatic-closing door in accordance with the 2006 NFPA 101, section 8.4.3.5. Interview with the facility maintenance staff at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility maintenance staff, and nurse manager at the time of exit confirmed the deficiency. REF: 2006 NFPA 101, Section 32.3.3.2, 8.7.1, 8.4, 8.4.3	S8015		
S8018	NFPA Life Safety - Nfpa Extinguishment Req NFPA 101 Extinguishment Requirements This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of testing	S8018		

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S8018	Continued From page 2 and maintenance of the water-based fire protection systems in accordance with the 2006 NFPA 101, Life Safety Code, and the 2002 NFPA 25, Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly maintain and test the water-based fire protection system could result in system failure, causing injury or death in an emergency. The deficiency affected the entire water-based fire protection system. The deficiency has the potential to affect all patients, staff, and visitors. The findings were: Observation on 10/21/2025 at 10:43 AM revealed the fire sprinkler in the entry closet in room 621 was missing an escutcheon. Failure to provide an escutcheon to seal the gap around the sprinkler could allow for smoke or heat to escape into the ceiling plenum, delaying the sprinklers activation. Observation on 10/21/2025 at 11:05 AM revealed a protective cover was installed over a fire sprinkler head in the bathroom closet in room 509. Further observation revealed the sprinkler was missing an escutcheon. The protective cover could prevent proper activation of the fire sprinkler, and obstruct the spray pattern in the event of a fire. The missing escutcheon could allow for fire or smoke to escape into the ceiling plenum, delaying the sprinkler activation. Interview with the facility maintenance staff and the nurse manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility maintenance staff, and nurse manager at the time of exit confirmed the deficiency.	S8018		

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S8018	Continued From page 3 Ref: 2006 NFPA 101 Section 32.3.3.5, 9.7.1.1(1), 9.7.5, 2002 NFPA 13 Section 6.2.7, 2002 NFPA 25 Table 12.1, Section 12.4.4.22.2.2	S8018		
S8030	NFPA Life Safety - Nfpa Miscellaneous NFPA 101 Miscellaneous This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to properly protect gas cylinders and eliminate sources of ignition in accordance with 2005 NFPA 99, Healthcare Facilities Code. Failure to properly protect cylinders and eliminate sources of ignition could result in injury or death. The deficiency could affect all residents, staff, within the affected area. The findings were: Observation on 10/21/2025 at 10:56 AM revealed an oxygen concentrator in use in room 505. Further observation revealed candles on display in room 505. No sources of open flame, including candles, shall be permitted in the areas of oxygen administration in accordance with the 2005 NFPA 99, section 9.6.1.1.2. Observation on 10/21/2025 at 11:00 AM revealed an oxygen gas cylinder laying on top of a table inside room 508. When cylinders are in use, they shall be attached to a cylinder stand or to a therapy apparatus of sufficient size to render the entire assembly stable per the 2005 NFPA 99, Section 9.4.3.3. Freestanding cylinders shall be properly supported in a cylinder stand or cart in	S8030		

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S8030	Continued From page 4 accordance with the 2005 NFPA 99, section 9.7.2.3(11). Interview with the facility maintenance staff and the nurse manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility maintenance staff, and nurse manager at the time of exit confirmed the deficiency. REF: 2005 NFPA 99 Sections 9.5.2.2, 9.6.1.1.2 and 9.7.2.3(11)	S8030		

This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.

S8015

1. Self-closing hinges are being installed on the dry storage pantry door identified in the List of Deficiencies. The hinges are certified hinges by Underwriters Laboratories (UL) and are National Fire Protection Association (NFPA) approved devices.
2. There is potential for all residents and staff to be adversely affected by a failed barrier system, preventing spread of fire or smoke. The Maintenance Department Director and staff conducted an inspection of the entire facility and found one additional door without self-closing capabilities. This door inside Room 632 "Soiled Utility", separates a mechanical room from the soiled utility room. The door is not a fire rated door, and may not be required by code, however, in the abundance of caution, approved self-closing hinges were installed on this door as well.
3. The Maintenance Director has added these doors to the routine inspection list and these doors will be included on the scheduled door inspections in our TELS® facility reporting system.
4. The Executive Director is responsible for ensuring the safety of residents and staff and will continue to monitor inspections and related system failures of any fire prevention systems. The Vetras Healthcare Corporate Safety Committee will review for compliance.
5. Completion date: November 30, 2025.

S8018

1. Sprinkler escutcheons were ordered and will be placed by our fire safety vendor, Nebraska Fire and Safety. The protective cover identified in the List of Deficiencies was removed at the time of inspection in the bathroom closet of Room 509. The escutcheons will be replaced in both the bathroom closet of Room 509 and the front entry closet of Room 621, as identified in the List of Deficiencies.
2. A facility tour was conducted by the Maintenance Director to review all similar areas to examine all sprinkler heads, no other violations were discovered during this inspection.
3. The List of Deficiency items was shared with our fire safety vendor, Nebraska Fire and Safety, to bring attention to this matter. The sprinkler system is regularly inspected by the vendor as part of the regularly scheduled quarterly, semi-annual and annual inspection processes.
4. Satff was educated on the importance of sprinkler functions. Memorandums were issued to staff to routinely watch for any potential defects to the sprinkler mechanisms and report any concerns to the Executive Director.
5. The Executive Director is responsible for ensuring the safety of residents and staff. The Maintenance Director or designee will conduct audit of sprinkler inspection reports and report to the Executive Director. Results of these audits will be brought to the Vetras Healthcare Corporate Safety Committee for review.
6. Completion date: November 30, 2025

S8030

1. 1)The candles identified in the List of Deficiencies in Room 505 have been removed from the premises. The facility has a no candle/no flame policy, regardless of the presence of oxygen. In this instance, the resident's daughter had brought in holiday display items that contained candles, a mere three days prior to survey. Normally, the housekeeping department would have detected the presence of these items on the normal scheduled cleaning day. Unfortunately, the items had not yet been discovered at time of survey. 2) Oxygen supplies and storage are contracted services by each individual resident. Currently, Lincare® is the only licensed oxygen vendor providing services to any resident of the facility. Supplemental bottled oxygen has been removed from Room 508, as the resident does not routinely use bottled oxygen and uses a portable oxygen concentrator. The bottle detailed in the List of Deficiencies was left over from a recent portable concentrator failure. All other bottled oxygen has been removed or properly secured by contracted vendor.
2. 1)All resident apartments were inspected for candles and other prohibited items, including but not limited to candles, space heaters, extension cords, etc. One other apartment, Room 528, was found to have a wick containing candles, capable of producing a flame, which was immediately removed from the premises. 2) All other residents receiving oxygen therapy was inspected by the licensed vendor, Lincare®, excess storage bottles were removed from three rooms, and all bottles not needed were removed, vendor also provided educational materials to the residents for safe storage and handling of their oxygen bottles and related equipment.
3. 1)Staff were educated on the prohibited items list and it was reiterated that any prohibited items must be removed and reported to the Executive Director immediately. 2)The oxygen service vendor was provided with the details of the related List of Deficiencies and requested to limit the storage and handling of oxygen equipment within standards. Education with individual residents was conducted by their contracted vendor.
4. 1) The Executive Director is responsible for ensuring the safe storage of oxygen. The Executive Director will follow up with the occupant of the room with any prohibited items. A warning letter was written and provided to the residents that had prohibited items in their respective apartments. The Executive Director also ensured that the topic of fire safety and prohibited items was discussed at the October 2025 Resident Council Meeting. 2)The Executive Director will follow-up with the oxygen vendors, every six months, to ensure compliance with all oxygen storage requirements for the facility. This information will be shared with the Vetras Healthcare Corporate Safety Committee for monitoring.
5. Completion date: November 8, 2025

END