Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF030	A. BUILDING: _____ B. WING _____	07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF CH	1530 DOROTHY LANE CHEYENNE, WY 82009

(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 complaint investigation survey was conducted by Healthcare Licensing and Surveys on July 23, 2021. The survey was prompted by complaint Intake LIC-26-067. The facility was a two story fully sprinklered building of Type V (111) construction built in 2013. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and an addressable fire alarm system. The facility had a capacity of 45 licensed beds with a census of 41 residents. Wyoming Department of Health Rules and Regulations for licensure of Assisted Living Facilities, Chapter 4, Section 10, Life Safety and Electrical Safety apply. Wyoming Department of Health Rules and Regulations for Administration of Assisted Living Facilities, Chapter 12, Section 7(0), Evacuation Capability, Emergency Procedures, and Fire Safety apply. The requirements in the Department of Health Chapter III, Construction Rules and Regulations for Healthcare Facilities apply. (i) Assisted Living Facilities in operation prior to the effective date of these rules shall meet the Life Safety Code of the National Fire Protection Association that was in effect at the time the facility was licensed as an All references are based on the requirements of the 2006 Edition of the NFPA 101, Life Safety Code, of the National Fire Protection Association	S 000		
S8004	NFPA Life Safety - Nfpa Doors NFPA 101 Doors	S8004		

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S8004	Continued From page 1 This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance-rated assembly door in accordance with the 2006 NFPA 101, Life Safety Code. Failure to maintain a fire resistance-rated assembly door as required could delay egress resulting in injury or death during an emergency. The deficiency affected one fire resistance rated door of many in the facility. The findings were: Observation on 7/23/2023 starting at 1:53 PM at the fire resistance-rated assembly doors separating the dining and independent living area on the north side of the first floor, when dropped with no initial motion via activated alarm, the door failed to latch and close completely. Further it was found that an additional four (4) fire resistance-rated assembly doors in the assisted living section on the first and second floors also failed to latch when dropped when activated during an alarm. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2006 NFPA 101, Sections: 32.1.5; 8.3.3.1; 8.3.3.3; Table 8.3.4.2	S8004		
S8027	NFPA Life Safety - Nfpa Emergency Egress & Rel Dr NFPA 101	S8027		

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S8027	Continued From page 2 Emergency Egress and Relocation Drills This State Rule and Regulation is not met as evidenced by: Based on observation, document review, staff interview, and resident interview, the facility failed to conduct emergency egress and relocation drills, and fire drills (emergency drills), to ensure that residents are able to meaningfully assist in their own evacuation in accordance with the 2006 International Fire Code (IFC), the 2006 NFPA 101, Life Safety Code (LSC), and the Wyoming Department of Health Rules and Regulations for Administration of Assisted Living Facilities, Chapter 12 (WDH Chapter 12). Failure to properly conduct emergency drills may result in injury or death in the event of an emergency. The deficiency affected the facility wide emergency response plan. The findings were: Document review of emergency drill records on 07/23/26, starting at 11:45 AM, review of these records, and interview with the facility administrator at the time of the document review, revealed residents were not required to participate in an evacuation, but were instead encouraged to return to their rooms and shelter in place. The records also revealed that incomplete information was recorded on the facility form. Records revealed the facility failed to conduct all required fire drills. Interview with the administrator revealed that the facility only did a full evacuation once per year. Per the IFC the evacuations shall be of the entire premise. Per the LSC, emergency drills may be announced, but must involve the actual evacuation of residents to an assembly point. These drills must be conducted monthly as amended by the Chapter 12 Rules, with two (2) drills occurring at night while residents are sleeping. At least one emergency	S8027		

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S8027	Continued From page 3 drill shall be run per shift per quarter. Records to include: date of the drill; Time of day; Type of drill (practice, announced, surprise); residents who participated including staff and family members; time required (minutes and seconds) to evacuate all residents (including staff) from occupied areas to a point of assembly; list of anyone, including staff and family members who did not evacuate in the required time allowed by the the evacuation capability rating of the facility; evacuation capability rating shall be listed on the form; comments on the factors that contributed to each individuals inability to evacuate successfully and any corrective actions recommenced; and the signature and date of the person completing the form. A surprise emergency drill was ran at the time of the survey at approximately 1:52 PM. They concluded the emergency drill after fourteen (14) minutes resulting in the facility receiving an impractical rating for the evacuation. The facility ended the emergency drill at fourteen (14) minutes while multiple residents were still evacuating down the stairs. Interview with the facility executive director at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility executive director at the time of exit confirmed the deficiency. Ref: 2006 International Fire Code Section 405.2, Table 405.2 2006 NFPA 101 Sections: 32.7.3.1; 32.7.3.2; 32.7.3.3; 32.7.3.6 WDH Chapter 12 Section 7(o)	S8027		

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Facility: Primrose Retirement Community of Cheyenne
Survey Date: July 23, 2026
Provider/Supplier ID: ALF030
Tag Number: S8004
Deficiency: Failure to Maintain Fire Resistance-Rated Assembly Doors

1. Corrective action for affected residents/areas: The facility will inspect the identified fire resistance-rated doors, including the doors separating the dining and independent living area and the additional assisted living doors cited during survey, to confirm proper closing and latching function when activated by the fire alarm system. Any door, latch, closer, release mechanism, or related hardware found not to function as required will be repaired, adjusted, or replaced. If additional technical evaluation is needed, the facility will coordinate with an appropriate qualified vendor or fire/life safety professional. Inspection findings, repairs, and follow-up actions will be documented and retained for regulatory review.

2. Identification of other areas that could be affected: The facility will complete a review of all fire resistance-rated doors throughout the assisted living and applicable independent living areas to identify any other doors or hardware that may not close, latch, or release as required. Any additional concerns identified during the review will be corrected and documented.

3. Measures/Systemic changes to prevent recurrence: Fire door inspections are part of the facility's ongoing maintenance and life safety monitoring process. The Maintenance Manager, who is newly assigned to the role, will receive additional training on fire resistance-rated door inspection expectations, life safety monitoring, corrective action follow-up, and required documentation. The Primrose Regional Maintenance Director will provide oversight, guidance, and follow-up support to ensure inspections are completed consistently and deficiencies are corrected timely.

4. Monitoring to ensure continued compliance: The Maintenance Manager will complete and sign off on a monthly inspection checklist for all fire resistance-rated doors. Documentation will include the date of inspection, doors inspected, findings, corrective action taken, date completed, and signature. The Executive Director and/or Primrose Regional Maintenance Director will review completed inspection documentation for compliance and follow-up as needed.

5. Responsible party and completion date: The Maintenance Manager is responsible for completion of fire door inspections and documentation, with oversight and support from the Primrose Regional Maintenance Director and Executive Director. Completion date: August 31, 2026.

Facility: Primrose Retirement Community of Cheyenne
Survey Date: July 23, 2026
Provider/Supplier ID: ALF030
Tag Number: S8027
Deficiency: Failure to Conduct and Document Required Emergency Egress and Relocation Drills

1. Corrective action for affected residents/areas: The facility currently has emergency preparedness, fire safety, and evacuation drill policies in place. Moving forward, the facility will ensure emergency egress and relocation drills are conducted, implemented, and documented in accordance with applicable State guidelines and Primrose guidelines. Staff and residents will be educated on drill expectations, including evacuation and relocation procedures, assembly point expectations, and documentation requirements, as applicable.

2. Identification of other residents/areas that could be affected: All residents, staff, shifts, and facility areas have the potential to be affected by emergency egress and relocation drill processes. The facility will review drill expectations for all shifts and applicable facility areas to ensure staff understand required procedures and residents are provided with education and practice opportunities appropriate to their abilities and safety needs.

3. Measures/Systemic changes to prevent recurrence: The facility will use the company's existing emergency drill documentation form to document required drill elements, including the date, time, type of drill, shift, participants, evacuation time, individuals not evacuated within the required time, evacuation capability rating, contributing factors, corrective actions, and signatures. Staff training will be initiated immediately and will include emergency egress procedures, resident direction and assistance, assembly point expectations, documentation requirements, and post-drill corrective action. Residents will receive education and practice sessions to support safe and meaningful participation in evacuation drills. The facility will initiate corrective action immediately and respectfully requests approval of a 90-day phased implementation period to ensure the revised full-premises evacuation drill process is implemented safely, consistently, and effectively for the assisted living population. During this period, the facility will complete staff education, provide written instructions, conduct resident education and practice sessions, complete leadership review of drill expectations, and progressively transition to full compliant drills while prioritizing resident safety.

4. Monitoring to ensure continued compliance: The Maintenance Manager/Emergency Preparedness Coordinator, with oversight from the Executive Director and support from the Primrose Regional Maintenance Director as needed, will review drill documentation after each drill to confirm completion, required elements, evacuation outcomes, identified concerns, and corrective actions. Drill performance will be discussed with appropriate leadership, and any identified issues will be addressed through follow-up training, process correction, or additional practice. Drill documentation will be retained for regulatory review. Ongoing monthly compliant drills will continue after implementation, including required nighttime drills as applicable.

5. Responsible party and completion date: The Maintenance Manager will serve as the facility's Emergency Preparedness Coordinator, with oversight from the Executive Director and support from the Primrose Regional Maintenance Director as needed. The Executive Director and Maintenance Manager/Emergency Preparedness Coordinator are responsible for implementation, education, drill completion, documentation, and monitoring. Corrective action will begin immediately. Written instructions and staff training will be completed within 30 days; resident education and practice sessions will be completed within 60 days; and the first full-compliant full-premises evacuation drill will be completed within 90 days, pending approval of the requested phased implementation period. The facility respectfully requests that a representative from the reviewing authority, or other appropriate fire/life safety official, conduct a mock evacuation drill with the Executive Director and leadership team during the implementation period to confirm expectations, identify any potential safety concerns, and support safe implementation. Completion date requested: November 11, 2026.

08/21/2026 - COMPLETION DATE REVISED TO OCTOBER 21, 2026, AS PER STATE REQUIREMENT