PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building with a basement of Type V (111) construction with plan approval in 1965. The building was equipped with a supervised automatic wet sprinkler system with two anti-freeze branches and an addressable fire alarm system. The facility had a capacity of 62 certified Medicare and Medicaid beds with a census of 56 residents.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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.*	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	**K-017 LIFE SAFETY CODE STANDARD** The ½ inch by 5 inch open section of the wall on the basement corridor wall has been closed. The facility's smoke compartments had their walls inspected for any open areas by the Maintenance Director. Any openings were patched immediately. The Maintenance Director/Designee will inspect all smoke compartments monthly for openings. Open areas will be repaired immediately. The results of the inspection will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 4/15/12

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.

PA ACCEPTED W/ TONY JAUREZ

ET, DN 4/16/12.

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 017	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor walls were smoke resistant in 1 of 5 smoke compartments. The findings were: Observation of the basement corridor walls on 2/27/12 at 1:04 PM showed a 1/2 inch by 5 inch section of the wall was missing near the base of the stairs. At the time of the observation the maintenance director reported he did not routinely inspect walls to ensure they were smoke resistant.	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K-018 LIFE SAFETY CODE STANDARD The corridor door to the Social Services office has been sealed and the strike plate has been repaired so the latch bolt inserts into the door frame. The facility's smoke compartments with corridor doors have been inspected for any unsealed areas around the door frame. Repairs were made to any unsealed areas. The Maintenance Director/Designee will inspect all smoke compartments with corridor doors monthly for unsealed areas around the door. Unsealed areas will be repaired immediately. The results of the inspection will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	533036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation of the social services office on 2:12 PM showed the corridor door had an unsealed gap of 1/2 inch by 42 inches along the lower half of the latch side of the door. Further observation showed the latch bolt did not insert into the strike plate which prevented the door from latching into the door frame. At the time of the observations the maintenance director reported office corridor doors were not routinely inspected.	K 018		
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure vertical shafts had fire rated walls which connected 2 of 6 smoke compartments. The findings were: Observation of the dumbwaiter on 2/27/12 at 1:20 PM showed a 12 inch by 18 inch section of the interior sheet rock wall was missing. Further observation showed the sheet rock had been	K 020	**K-020 LIFE SAFETY CODE STANDARD** The 12" by 18" section of the interior sheet rock wall of the dumbwaiter has been repaired with one hour fire resistant sheet rock. There are no other vertical shafts connecting two smoke compartments to inspect. The Maintenance Director/Designee will inspect the vertical shaft walls of the dumb waiter for open or worn areas monthly. Noted open or worn areas will be repaired immediately. The results of the inspections will be reported to the monthly PI for review and evaluation for corrective actions until resolved.	4/15/12

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 020	Continued From page 3 worn smooth next to the missing section of the wall. At the time of the observation the maintenance director reported he did not routinely inspect the dumbwaiter walls to ensure they were intact.	K 020		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 4 smoke barrier walls were smoke resistant. The findings were: Observation of the east attic smoke barrier wall on 2/27/12 at 3:40 PM showed a 2 foot by 4 foot access hole had been cut into the wall. Further observation showed the opening was not equipped with a door. At the time of the observation the maintenance director reported an ventilation project was completed in November 2011 and the contractor must have cut the access hole. He also reported the attic smoke barrier walls were not routinely inspected.	K 025	**K-025 LIFE SAFETY CODE STANDARD** The east attic smoke barrier wall has been repaired with half hour fire resistance rating sheet rock. The Maintenance Director inspected smoke barrier walls in the attic for opens with repairs made when necessary. The Maintenance Director/Designee will inspect the smoke barrier walls in the attic monthly and after any work performed in the attic which requires smoke barrier wall breach for openings. Repairs will be made when necessary. The results will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 16TH STREET RAWLINS, WY 82301

(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 029 SS=E	Continued From page 4 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 3 of 5 smoke compartments. The findings were: 1. Observation of the maintenance shop on 2/27/12 at 12:52 PM showed the corridor door was held open by a rubbed wedge placed under the door. At the time of the observation the maintenance director reported he was aware corridor doors to hazardous areas are prohibited from being propped open; however, he could not explain why the wedge was used. 2. Observation on 2/27/12 between 12:30 PM and 2:30 PM showed the boiler room had two unsealed pipe penetrations. The largest gap measured 3/8 of an inch across. At 12:57 PM the maintenance director reported the boiler room was only inspected on an annual basis. Further observation showed the south hall dirty linen	K 029	**K-029 LIFE SAFETY CODE STANDARD** The rubber wedge has been removed from the maintenance shop door. The boiler room has had the pipe penetration holes repaired and the wall in the south dirty linen room has had the hole in the wall patched. The corridor door for the washer room has had the self-closing device adjusted so it will fully latch into the door frame without assist. The Maintenance Director has checked the facility self-closing corridor doors to ensure that they fully latch into the door frame and that any rubber wedges are removed so the doors remain closed. The facility's smoke compartments had their walls inspected for any open areas by the Maintenance Director. Any openings were patched immediately. The Maintenance Director/Designee will inspect all smoke compartments monthly for openings and for self-closing doors latching to the door frame. Open areas and self-closing doors that don't latch will be repaired immediately. The results of the inspection will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 029	Continued From page 5 room had a 1 inch by 10 inch hole in the wall from cart damage. At 2:29 PM he reported damaged walls should have been submitted as a work order by facility staff. 3. Observation of the laundry on 2/27/12 at 3:52 PM showed the corridor door for the washer room was equipped with a self-closing device. Further observation showed the self-closing device was not able to fully latch the door into the door frame with three attempts. At the time of the observation the maintenance director could not explain why the door had not been noticed and repaired during the quarterly inspections.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure exit discharge pathways servicing 2 of 5 smoke compartments were unobstructed. The findings were: Observation of the south patio on 2/27/12 at 2:46 PM showed the exit pathway was obstructed by two lawn chairs sitting on the sidewalk. At the time of the observation the maintenance director could not explain why the chairs had not been noticed and removed from the pathway during the monthly inspections. Further observation showed the door knob for the south patio exterior gate	K 038	**K-038 LIFE SAFETY CODE STANDARD** The south patio has had the exit pathway cleared of lawn chairs. The door knob for the south patio exterior gate has been adjusted in order to allow operation with one hand per code. The Maintenance Director has inspected the facility's other exit pathways and removed any obstacles or obstructions. The Maintenance Director/Designee will monitor the facility exit pathways during daily walkthroughs and remove any obstacles or obstructions and report any concerns to the monthly PI meeting for review and evaluation for corrective actions until resolved.	4/15/12

PRINTED: 03/
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

(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 038	Continued From page 6 was located 1/2 inch from the door frame and pinched the fingers when operating the knob. At 2:55 PM the maintenance director reported he was unaware door knobs required adequate operating space. Reference, NFPA 101, 2000 Edition, 19.2.2.2.1; 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions... A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars... The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the emergency generator was equipped with a remote manual stop station. The findings were: Observation of the emergency corridor lights showed they were supplied with power from the emergency generator. Observation of the generator on 2/27/12 at 3:58 PM showed it was not equipped with a remote stop station external of the weatherproof enclosure. At the time of the observation the maintenance director confirmed the generator was not equipped with an external	K 046	**K-046 LIFE SAFETY CODE STANDARD** The Maintenance Director has submitted a drawing and plans to the State Engineer for the installation of a remote manual stop station external from the emergency generator. On 3/20/12 the Engineer stated that if he has not had the opportunity to approve the plans by 3/28/12 that is alright to proceed with the installation. A quote from L&L Electric will be obtained by 3/28/2012 for the installation of the remote manual stop station. The installation of the remote manual stop station will be completed on or before ~~4/15/2012~~.	4/15/12

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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 046	Continued From page 7 remote stop station. He further reported the generator was installed in 2004. Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 3-5.5.6 All Level 1 and Level 2 installations shall have a remote manual stop station of a type similar to the break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff members were familiar with emergency procedures on 1 of 3 shifts. The findings were; Observation of the fire drill on 2/27/12 at 4:55 PM showed the south smoke compartment was the simulated area of fire origin. Further observation showed resident #1 was left in the south patio room while three certified nurse assistants and	K 050	**K-050 LIFE SAFETY CODE STANDARD** The Maintenance Director educated the staff on the facility Emergency Manual's Fire Drill policy. The Maintenance Director will conduct one fire drill per shift per week for one month then as per facility policy thereafter. The results of the drill will be presented to the monthly PI meeting for review and evaluation for corrective actions until resolved.	4/15/12

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 16TH STREET RAWLINS, WY 82301

(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 050	Continued From page 8 three nurses walked past the resident. At 5:02 PM registered nurse #2 stated the resident should have been moved to the other side of the closest smoke barrier. She could not explain why the resident was not moved out of the smoke compartment of fire origin.	K 050		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were properly maintained in 1 of 6 smoke compartments. The findings were: Observation of the kitchen "K" type wet fire extinguisher on 2/27/12 at 3:44 PM showed the last hydrostatic test was performed in September 2005, more than five years ago. At the time of the observation the maintenance director reported he assumed the extinguisher contractor would monitor the service schedule. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.4.1, NFPA 10, 1999 Edition; Table 5-2 Hydrostatic Test Intervals for Extinguishers Wet Agent----------5 years	K 064	**K-064 LIFE SAFETY CODE STANDARD** The K type wet fire extinguisher in the kitchen has had the hydrostatic test performed by the extinguisher contractor. There are no other K type wet fire extinguishers in the facility to be checked. The Maintenance Director will check all extinguishers in the facility monthly for up to date maintenance and non-compliant extinguishers will be brought into compliance. The results of the check will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no	K 066		

FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 066	Continued From page 9 less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure noncombustible ashtrays were provided at 1 of 4 designated smoking areas. The findings were: Observation of the south patio smoking area on 2/27/12 at 2:46 PM showed numerous cigarette butts and empty cigarette packs were disposed of in a plastic container. Further observation showed the container was a thin plastic plant pot. At the time of the observation the maintenance director	K 066	**K-066 LIFE SAFETY CODE STANDARD** The south patio are had the cigarette butts and empty cigarette packs removed and the plastic plant pot removed. The ED educated all staff and residents who smoke on the proper smoking location and disposal ashtray. The Maintenance Director/Designee will monitor the improper disposal of cigarette butts in the south patio area during his daily walk through. Immediate corrective action will take place when necessary. Concerns will be brought to the monthly PI meeting for review and evaluation for corrective action until resolved.	4/15/12

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 16TH STREET RAWLINS, WY 82301

(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 066	Continued From page 10 reported he was unaware ashtrays are required to be noncombustible material and safe design.	K 066		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure candles were prohibited in 1 of 5 smoke compartments. The findings were: Observation of the staff development office on 2/27/12 at 1:47 PM showed a candle in a glass jar was lit in the restroom. At the time of the observation registered nurse #1 stated she lit the candle for the aroma. She also stated she was unaware lit candles were prohibited in healthcare facilities. The candle was extinguished immediately after the observation.	K 073	**K-073 LIFE SAFETY CODE STANDARD** The glass jar with a candle in it was removed immediately by the Maintenance Director. A walk through of the facility by the Maintenance Director was completed and any furnishings or decorations which did not meet the Life Safety Code Standard were immediately removed. The facility staff had been educated on the Life Safety Code Standard regarding furnishings or decorations of highly flammable character by the Maintenance Director.	4/15/12
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13	K 074	The Maintenance Director/Designee will monitor the facility during daily rounds for any furnishings or decorations which do not meet the Life Safety Code Standard. Violations will be removed immediately. The results of the daily rounds will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved. **K-074 LIFE SAFETY CODE STANDARD** The curtains in the activity office were removed immediately and sprayed with an approved fire retardant spray.	4/15/12

PRINTED: 04/10/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536030	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 074	Continued From page 11 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure curtains were flame retardant in 1 of 5 smoke compartments. The findings were: Observation of the activities office on 2/27/12 at 2:37 PM showed the window curtains did not have flame retardant documentation attached to them. At the time of the observation the maintenance director reported the aforementioned curtains did not have a flame retardant solution applied to them.	K 074	A walk through of the facility by the Maintenance Director was completed and any furnishings or decorations (including curtains) which did not meet the Life Safety Code Standard were immediately removed. The facility staff had been educated on the Life Safety Code Standard regarding furnishings or decorations (including curtains) of highly flammable character by the Maintenance Director. The Maintenance Director/Designee will monitor the facility during daily rounds for any furnishings or decorations (including curtains) which do not meet the Life Safety Code Standard. Violations will be removed immediately. The results of the daily rounds will be reported to the monthly PI meeting for review and evaluation for corrective action until resolved.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview, the	K 144	K-144 LIFE SAFETY CODE STANDARD The missed generator check occurred in the past and cannot be remedied. The Maintenance Director reviewed the Life Safety Code Standard K-144 regarding monthly generator full load testing.	4/15/12

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	042 16TH STREET RAWLINS, WY 82301

(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 144	Continued From page 12 facility failed to ensure the emergency generator was tested under load during 1 of the past 12 months. The findings were: Review of the emergency generator testing records showed a monthly full load test had not been performed during January 2012. On 2/27/12 at 4:50 PM the maintenance director confirmed the test had not been conducted. He could not explain why the test was missed.	K 144	The Maintenance Director will run a monthly generator full load test per Life Safety Code Standard K-144. The results of the test will be presented to the monthly PI meeting for review and evaluation for corrective action.	