DEPARTMENT OF HEALTH AND HUM. 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
	535021	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 the 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 partial basement of Type II (000) construction built in 1981. The building was equipped with a supervised automatic wet fire sprinkler system with an anti-freeze branch and addressable fire alarm system.	K 000		
K 017 SS=D	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 This STANDARD is not met as evidenced by: Based on observation and staff interview the	K 017	K017 The facility will ensure corridor walls are smoke resistant. This will be accomplished by: 1) Three (3) unsealed holes in the wall will be filled.	11/30/2010

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

X [signature] — X RNNHA Facility Manager — 11/15/10

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.

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K 017	Continued From page 1 facility failed to ensure corridor walls were smoke resistant in 1 of 10 smoke compartments. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed the corridor wall above the fire extinguisher in pod B had three unsealed holes in the wall. In addition, a thermostat recessed into the wall in the special care unit had a gap around it. Interview with maintenance staff at the time of the observations verified the area around the thermostat needed to be caulked.	K 017	K017 cont'd 2) The gap around the thermostat in the special care unit will be filled. 3) Environmental Services Dept. will be in-serviced on ensuring corridor walls are smoke resistant. 4) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010
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. This STANDARD is not met as evidenced by: Based on observation and staff interview, the	~~K 018~~		

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K 018	Continued From page 2 facility failed to ensure one corridor door was resistant to the passage of smoke in 1 of 10 smoke compartments. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed the corridor door to resident room #320 on pod B did not close completely in its frame unless force in excess of 5 foot pounds of pressure was applied. Interview with the maintenance manager at the time of the observation confirmed the door did not seat in its frame and should be adjusted.	K 018	K018 The facility will ensure corridor doors are resistant to the passage of smoke. This will be accomplished by: 1) Hinges were adjusted on resident room #320 so that the door closes completely in its frame.	11/30/2010
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 4 of 8 smoke barrier doors were resistant to the passage of smoke. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed four cross-corridor smoke barrier doors did not form a tight seal when closed. A quarter inch to s half inch gap existed between the doors when closed. The doors were in the following locations:	~~K 027~~	2) Environmental Services Dept. will be in-serviced on ensuring corridor doors are resistant to the passage of smoke. 3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010

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	636021	A. BUILDING D1 B. WING _____	10/14/2010

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K 016	Continued From page 2 facility failed to ensure one corridor door was resistant to the passage of smoke in 1 of 10 smoke compartments. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed the corridor door to resident room #320 on pod B did not close completely in its frame unless force in excess of 5 foot pounds of pressure was applied. Interview with the maintenance manager at the time of the observation confirmed the door did not seat in its frame and should be adjusted.	~~K 016~~	K027 The facility will ensure all smoke barrier doors are resistant to the passage of smoke. This will be accomplished by: 1) The door leading to the south wing and the doors into north pods A,B and C will be replaced.	11/30/2010
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 4 of 8 smoke barrier doors were resistant to the passage of smoke. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed four cross-corridor smoke barrier doors did not form a tight seal when closed. A quarter inch to s half inch gap existed between the doors when closed. The doors were in the following locations:	K 027	3) Environmental Services Dept. will be in-serviced on ensuring all smoke barrier doors are resistant to the passage of smoke. 4) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010

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K 027	Continued From page 3 1.The door leading into the south wing. 2.The doors into pods "A", "B" and "C" in the north wing. The maintenance manager confirmed the observation and stated the doors were getting old and needed to be replaced.	~~K 027~~	K029 The facility will ensure all hazardous areas are separated from patient use areas. This will be accomplished by:	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 all hazardous areas were separated from patient use areas in 1 of 10 smoke compartments. The findings were: Observation on 10/13/10 at 2:48 PM revealed the biohazard door in the infection control office had a self closure device attached. However, the door did not latch in its frame upon three separate attempts. Interview with the maintenance manager at the time of the observation confirmed the door did not seal properly in its frame.	K 029	1) The door hinges on the biohazard door in the infection control office were adjusted so the door closes completely. 2) Environmental Services Dept. will be in-serviced on ensuring all hazardous areas are separated from patient use areas. 3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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K 056	Continued From page 4 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all sprinkler heads in 2 of 10 smoke compartments were installed as required. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed six sprinkler head covers were missing from the following locations: a. Resident room #216 (bathroom). b. Resident room #217 (bathroom). c. North nurses' station bathroom. d. Resident room #215 including the bathroom (a total of three missing covers). Interview with the maintenance manager at the time of the observations confirmed the sprinkler head covers were missing. The manager stated at the time the roofing project was causing the covers to fall off.	K 056	K056 The facility will ensure all sprinkler heads are installed as required. This will be accomplished by: 1) Sprinkler head covers were replaced in: a. Resident bathroom #216 b. Resident bathroom #217 c. Bathroom of north nurses' station d. Three covers in resident room #215 including the bathroom	11/30/2010
			2) Environmental Services Dept. will be in-serviced on ensuring all sprinkler heads are installed as required.	11/30/2010
			3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	~~K 062~~		

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K 062	Continued From page 5 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinkler heads were properly maintained in 2 of 10 smoke compartments. The findings were: Observation on 10/13/10 between 11:30 AM and 3 PM revealed gaps greater than half an inch existed between the sprinkler head escutcheons and the ceiling in the following locations: a. Resident Room #204 b. Resident Room # 222 c. Resident Room #220 (bathroom) d. Resident room #227 (closet) e. The chapel Interview with the maintenance manager at that time of the observations confirmed the above observations.	K 062	K062 The facility will ensure all sprinkler heads are properly maintained. This will be accomplished by: 1) Gaps have been filled around sprinklers in: a. Resident room #204 b. Resident room #222 c. Resident bathroom #220 d. Resident room #227 (closet) e. Chapel 2) Environmental Services Dept. will be in-serviced on ensuring all sprinkler heads are properly maintained. 3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure facility electrical wiring was in compliance with the National Electric Code in 1 of 10 smoke compartments. The findings were: Observation on 10/13/10 at 1:48 PM revealed a surge protector was plugged into another surge	~~K 147~~		

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K 147	Continued From page 6 protector in the human resource office and in the health information office. At the time of the observations the maintenance manager confirmed the findings and stated the maintenance staff frequently does rounds in an attempt to keep this from happening.	K 147	K147 The facility will ensure all electrical wiring is in compliance with the NEC. This will be accomplished by:	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. . o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	~~K 211~~	1) Two surge protectors were replaced with one larger surge protector in both the human resource office and in the health information office.	11/30/2010
			2) Environmental Services Dept. will be in-serviced on ensuring all electrical wiring is in compliance with the NEC.	11/30/2010
			3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed over ignition sources in 3 of 10 smoke compartments. The findings were: Observation on 10/13/10 at between 11:30 AM and 3:00 PM revealed 14 ABHR dispensers were attached to the wall directly over a light switches in the following locations:			

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K 211	Continued From page 7 a. Resident room #308. b. Beauty shop. c. Staff dining room. d. Resident rooms #203 and #215 in the north wing. e. Resident rooms #220, #221, #222, #223, #224 and #225 in pod "B" SCU unit. f. Resident rooms #205, #209 and #215 in pod "A" Interview with the maintenance manager at the time of these observations confirmed the dispensers were located directly above light switches.	K 211	K211 The facility will ensure ABHR dispensers are not installed over ignition sources. This will be accomplished by: 1) ABHR dispensers have been moved away from the light switches in the following locations: a. Resident room #308 b. Beauty shop c. Employee dining room d. Resident rooms #203, #215 e. Resident rooms #220, #221, #222, #223, #224 and #225 f. Resident rooms #205, #209 and #215 2) Environmental Services Dept. will be in-serviced on ensuring ABHR dispensers are not installed over ignition sources. 3) Environmental Services Manager to audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010