PRINTED: 10/18/2012
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
	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 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. The facility was a fully sprinkled single story building of Type II (000) construction with a basement built in 1981. 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 90 certified Medicare and Medicaid beds with a census of 66.	K 000	This Plan of Correction Constitutes Our Allegation Of Compliance.	11/26/12
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire barrier was continuous from floor to ceiling. The findings were: Observation of the fire barrier on 10/2/12 at 12:10 PM showed two unsealed conduit penetrations. The largest gap measured 1 inch by 2 inches. At	K 011	The facility will ensure that fire barriers are continuous from ceiling to floor. This will be accomplished by: a) The two unsealed conduit penetrations in the fire barrier have been repaired. b) Maintenance staff will be in serviced on ensuring that fire barriers are continuous from ceiling to floor. c) Environmental Services Manager or designee to monitor monthly for compliance and report results quarterly through the Quality Improvement (QI) process for review/recommendations.	11/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Cox-Mills — TITLE: Facility Manager — (X6) DATE: 10/25/12

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.

LSC PoC found to be acceptable on 10/26/12 by Ken Sum

Copy sent to SSA on 10/29/12.

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WYOMING RETIREMENT CENTER	590 US HWY 20 SOUTH BASIN, WY 82410

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K 011	Continued From page 1 the time of the observation the environmental services manager could not explain why the holes had not been noticed and repaired during the monthly inspections.	K 011		11/26/12
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 7 smoke barrier walls was smoke resistant. The findings were: Observation of the south A-pod smoke barrier on 10/2/12 at 11:50 AM showed two unsealed penetrations. The largest gap measured 1 inch by 18 inches. At the time of the observation the environmental services manager could not explain why the holes had not been noticed and repaired during the monthly inspections.	K 025	The facility will ensure that smoke barrier walls are smoke resistant. This will be accomplished by: a) The two unsealed penetrations in the South A-Pod smoke barrier have been sealed. b) Maintenance staff will be in serviced on ensuring that fire barrier walls are smoke resistant. c) Environmental Services Manager or designee will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12
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	K 027		

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K 027	Continued From page 2 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 3 of 7 smoke barrier double doors were smoke resistant. The findings were: Observation on 10/2/12 between 8:30 AM and 11:30 AM showed one of two double smoke barrier doors were unable to fully latch into the door frame at the following locations, with three attempts each: a North Library smoke barrier doors b South A-Pod smoke barrier doors c South B-Pod smoke barrier doors On 10/2/12 at 11:14 AM the environmental service manager could not explain why the aforementioned doors had not been noticed and repaired during the monthly safety inspections.	K 027	The facility will ensure smoke barrier double doors are smoke resistant. This will be accomplished by: a) The North Library, South A and B-Pod smoke barrier doors have been repaired so they now fully latch. b) Maintenance staff will be in serviced on ensuring the smoke barrier double doors latch so they are smoke resistant. c) Environmental Services Manager or designee will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12
K 029 SS=E	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	K 029		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	850 US HWY 20 SOUTH BASIN, WY 82410

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K 029	Continued From page 3 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 1 of 8 smoke compartments. The findings were: 1. Observation of the basement boiler room on 10/2/12 at 8:17 AM showed five unsealed pipe penetrations. The largest gap measured eight inches by 24 inches. At the time of the observation the environmental service manager could not explain why the holes had not been noticed and repaired during the quarterly safety inspections. 2. Observation of the medical records storeroom on 10/2/12 at 8:30 AM showed the corridor was not provided with a self-closing device. Further observation showed five unsealed conduit penetrations above the ceiling tiles. The largest gap measured 4 inches by 12 inches. At the time of the observation the environmental services manager reported the room was turned into the medical records storeroom in October 2011. She further reported that she was unaware of the aforementioned requirements.	K 029	The facility will ensure hazardous areas are separated from use areas. This will be accomplished by: a) The five unsealed pipe penetrations in the basement boiler room have been sealed. b) A self-closing device has been installed on the corridor door of the medical records storeroom and the conduit penetrations above the ceiling tiles have been sealed. c) Maintenance staff will be in serviced on ensuring hazardous areas are separated from use areas. d) Environmental Services Manager or designee to audit monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12
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.	K 050		

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WYOMING RETIREMENT CENTER	630 US HWY 20 SOUTH BASIN, WY 82410

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K 050	Continued From page 4 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 record review, observation and staff interview the facility failed to ensure fire drills were held at varying times on 1 of 3 shifts and failed to ensure staff members were familiar with required procedures on 1 of 3 shifts. The findings were: 1. Review of the fire drill testing records showed the first shift occurred between 7 AM and 3 PM. Further review showed the past three drills on the first shift occurred between 6:05 AM and 9:30 AM. Further review showed a fire drill had not been conducted during on the first shift during the second quarter of 2012. On 10/2/12 at 2:11 PM environmental services manager reported she was unaware drills were supposed to be conducted at varying times. She could not explain why the drill was held at 3:35 PM on 4/24/12 instead of during the first shift. 2. Observation of the fire drill on 10/2/12 at 2:20 PM showed two of the resident room corridor doors in the smoke compartment of fire origin were not closed. Further observation showed an isolation cart was obstructing the corridor throughout the drill. On 10/2/12 at 2:24 PM	K 050	The facility will ensure fire drills are held at varying times and that staff are familiar with the procedures. This will be accomplished by: a) RN#1 and all staff will be in-serviced on ensuring doors are closed when a fire alarm is activated, and that corridors are cleared. b) Maintenance staff will be in serviced regarding ensuring that fire drills are conducted at varying times. c) Environmental Services Manager or designee will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12

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K 050	Continued From page 5 registered nurse #1 reported she was unaware the doors were required to be closed throughout the smoke compartment. She was also unaware all corridors were required to be cleared of obstructions with the activation of the fire alarm system.	K 050		11/26/12
K 062 S6=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating 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 sprinklers were properly maintained in 1 of 8 smoke compartments and failed to ensure 1 of 5 sprinkler system test was performed. The findings were: 1. Observation of resident room #314 on 10/2/12 at 11:02 AM showed the closet sprinkler head was located less than the allowed 4 inches from the wall. The sprinkler head was installed 2 inches from the wall. At the time of the observation the environmental services manager reported she was unaware of the spacing requirement. She also reported the annual inspection of the sprinkler system was conducted by the maintenance staff and they were unaware of the said requirement as well. 2. Review of the sprinkler system testing records showed the facility did not have a record of the last annual back flow preventer test. On 10/2/12	K 062	The facility will ensure that sprinklers are maintained and that sprinkler tests are performed. This will be accomplished by: a) The closet sprinkler head in room #314 has been relocated so that it is 4 inches from the wall. b) The back flow preventer test has been ordered. c) Maintenance staff will be in serviced regarding sprinkler heads being properly maintained, sprinkler testing requirements, such as the back flow preventer test. d) Environmental Services Manager or designee will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12

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K 062	Continued From page 6 at 2:11 PM the environmental services manager confirmed there were no records to review. She also reported that she was unaware of this requirement. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 8-6.3.3 Sprinklers shall be located a minimum of 4 in. from the wall. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5 NFPA 25, 1998 Edition; 9-6.2.1 All backflow preventers installed in fire protection system piping shall be tested annually ...	K 062		11/26/12
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 temporary electrical wiring did not replace permanent fixed wiring in 1 of 8 smoke compartments. The findings were: Observation of resident room #303 on 10/2/12 at 10:43 AM showed the radio was plugged into two surge protectors in-line. At the time of the observation the environmental service manager could not explain why the electrical adapter had not been noticed and removed during the monthly safety inspections. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8, Uses not permitted. Unless specifically	K 147	The facility will ensure temporary electrical wiring does not replace permanent fixed wiring in smoke compartments. This will be accomplished by: a) The radio in resident room #303 is now plugged into only one surge protector. b) Maintenance, housekeeping and nursing staff will be in serviced regarding not allowing temporary wiring to replace permanent fixed wiring in smoke compartments. c) Environmental Services Manager or designee will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12

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K 147	Continued From page 7 permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		11/26/12