STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABILITATION CENTER	1002 FOREST DRIVE RIVERTON, WY 82501

(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 of Type V (111) construction built in 1966. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system.	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 of 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 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:	K 018	K 018 Life Safety Code Standard This will be met as evidenced by: a. Door Seating for doors #17, #22, and #36 will be adjusted to fit frame for appropriate closure. b. All door closures will be checked by Maintenance Director/Designee to assure they are closing properly. c. Maintenance Director will complete routine PM rounds to assure proper door closures are maintained. d. Noted concerns will be referred to the PI Committee by the Maintenance Director/Designee for further review and recommendations, if indicated.	4/16/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 04-03-10

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 018	Continued From page 1 Based on observation and staff interview, the facility failed to ensure corridor doors were resistant to the passage of smoke in 2 of 6 smoke compartments. The findings were: Observation on 3/10/10 between 11:32 AM and 2:18 PM revealed corridor doors to resident rooms #17, #22 and #36 did not close completely in their frames unless force in excess of 5 foot pounds of pressure was applied. Interview with the facility maintenance manager at that time of the observation confirmed the doors did not seat in their frames and should be adjusted.	K 018	*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 of 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 038 SS=D	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 facility exit access was unobstructed in 3 of 6 smoke compartments. The findings were: Periodic observation on 3/8/10 at 4:48 PM through 3/10/10 at 2:18 PM revealed the following concerns: a hard wood chair was situated in the back hallway just outside the bathing room and another hardwood chair was situated in the front hallway outside the front bathing room. In addition, an electric wheelchair was also observed during this time period sitting in the hallway in front of the north exit. Interview with facility maintenance manager on 3/10/10 at 2:18	K 038	~~K 038 Life Safety Code Standard~~ This standard will be met as evidenced by: a. Noted hardwood chairs and electric wheelchairs will be removed from the hallway. b. Chairs & other equipment will be routinely removed from the hallway anytime they are left without use for >30 minutes c. Staff will be inserviced regarding expectations for exit accessibility by the Maintenance Director/designee. Maintenance Director/Designee will make routine rounds to assure ongoing compliance. d. Results of rounds will be referred to the PI Committee by the Maintenance Director for review and recommendations.	4/16/10

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K 038	Continued From page 2 PM confirmed these observations. In addition, interview with the director of nursing on 3/11/10 at 9:22 AM revealed the wheelchair belonged to a resident who had not used the chair the previous several days.	K 038	*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 of 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 062 SS=D	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	K 062	K 062 Life Safety Code Standard This standard will be met as evidenced by: a. Gaps of > 1 inch between ceiling and sprinkler head escutcheons will be eliminated in the kitchen dry storeroom and in the two noted locations in the rehabilitation room. Escutcheon will be replaced on sprinkler heads in the hallway outside resident room #41, #15, #44 and on those missing in the main dining room. b. Maintenance Director/Designee will complete facility rounds to determine that all ceiling and sprinkler head escutcheons gaps meet requirements and that all sprinkler heads have escutcheons. c. Preventative Maintenance rounds performed by the Maintenance Director/Designee will include checks on sprinkler head escutcheon gaps and sprinkler head escutcheons to determine that compliance is ongoing. d. Results of rounds will be referred to the PI Committee by the Maintenance Director/Designee for review and recommendations if indicated.	4/16/10
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire suppression (sprinkler) system was properly maintained. The findings were: Observation on 3/10/10 between 11:32 AM and 2:18 PM revealed the following concerns: a. A gap greater than one-inch existed between the sprinkler head escutcheon and the ceiling in the kitchen dry storeroom and in two locations in the rehabilitation room. b. An escutcheon was observed to be missing on the sprinkler heads in the hallway outside resident rooms #41, #15, #44. Two of the sprinkler heads in the main dining room also had missing escutcheons. c. Interview with the maintenance manager at the time of the observations confirmed the above.			
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	K 064		

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K 064	Continued From page 3 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to maintain 2 of 12 portable fire extinguishers as required. The findings were: Observation on 3/10/10 between 11:32 AM and 2:18 PM revealed an "ABC" type of fire extinguisher attached to the wall at the foot of the basement stairs. The top of the fire extinguisher was approximately six feet from the floor, exceeding the maximal five and one half feet requirement for extinguishers weighing less than 40 pounds. In addition, the "K" type fire extinguisher in the kitchen was located on the bottom shelf of a storage unit in the kitchen. Two boxes of tea bags obstructed the extinguisher. Interview with the maintenance manager at the time confirmed the above observations.	K 064	*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 of 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 064 Life Safety Code Standard This standard will be met as evidenced by: a. "ABC" type fire extinguisher at the foot of the basement stairs will be located at a height to meet requirements of the maximal five and one half feet from floor. "K" type fire extinguisher in the kitchen will be located in accessible location per regulation. Maintenance Director/Designee will be responsible for these tasks. b. Maintenance Director/Designee will complete rounds of fire extinguishers throughout building to determine that fire extinguisher placement is in compliance. c. Maintenance Director/Designee will oversee the movement of existing fire extinguishers and the placement of new extinguishers to determine that compliance is maintained. d. Maintenance Director will present any identified concerns to the PI Safety Committee for review and recommendations	4/16/10
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 compliance with the National Electrical Code in 1 of 6 smoke compartments. The findings were: Observation on 3/10/10 between 11:32 AM and 2:18 PM revealed the electrical box to an emergency outlet in the hallway outside resident	K 147		

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K 147	Continued From page 4 room #38 was not firmly attached to the wall stud. The maintenance manager stated at the time, "Someone in a wheelchair most likely bumped up against the outlet, dislodging it."	K 147	*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 of 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 147 Life Safety Code Standard This standard will be met as evidenced by: a. Electrical box to the emergency outlet in the hallway outside resident room #38 will be firmly attached to a wall stud. b. Electrical boxes throughout facility will be secured in compliance with requirements. c. PM rounds routinely completed by the Maintenance Director/Designee will include checks on placement of electrical boxes to determine ongoing compliance. d. Identified concerns will be presented to the PI Safety Committee by the Maintenance Director/Designee for review and recommendations.	4/16/10