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

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
	535031	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/31/2010

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

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1962, 1992 K7 SURVEY UNDER: 2000 Existing K8 SNF Type of Structure: Type V (111) 1962 one story, protected wood frame with a partial basement, a 1992 Type V (111) kitchen and rehab building addition. The facility has a complete automatic (wet) sprinkler system and eight smoke compartments. A Comparative Federal Monitoring Survey was conducted on 03/31/10, following a State Agency Annual Survey on 03/14/10 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Wind River Healthcare & Rehab Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	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 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	K 027	K027 This will be met as evidenced by; a. Smoke doors located at the Copper Mountain wing will have an obstacle strip applied to assure smoke door gap will be 1/8 inch or less.	5/10/10

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

ED | 04-23-10

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 027	Continued From page 1 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 interview, the facility failed to maintain smoke doors that would close and resist the passage of smoke. The deficient practice affected two of eight smoke compartments, staff and approximately 28 residents. The facility has the capacity for 88 beds and at the time of the survey the census was 72. Findings include: Observation on 03/31/10 at 10:15 a.m. revealed that the smoke doors located at the Copper Mountain wing had a gap between the doors when closed. The gap between the doors was 1/8 inch at the top expanding to 1/2 inch at the bottom. Interview with the facility Maintenance Supervisor on 03/31/10 at 10:15 a.m. revealed that the facility was not aware that the smoke doors were not smoke resistive with and that there was more than an 1/8 inch gap between the doors when the doors were closed. The census of 72 was verified by the Administrator on 03/31/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/31/10. Actual NFPA Standard: NFPA 101, 19.3.7.6*, Requires doors in smoke barriers to be	K 027	b. Maintenance Director will check gaps in all smoke doors to assure gap compliance is met. Any smoke doors with gaps found to be greater than 1/8 inch will have obstacle strips applied to meet requirement. c. Maintenance Director/Designee will complete routine preventative maintenance rounds to assure that smoke door gaps are maintained at 1/8 inch or less. d. The Maintenance Director/Designee will present trends/concerns related to smoke door gap closures to the PI Committee for review and further action if indicated.	

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K 027 K 039 SS=E	Continued From page 2 self-closing and resist the passage of smoke. NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain clear width of an exit corridor. This condition affected two of eight smoke compartments, the staff and approximately 16 residents. The facility has the capacity for 88 beds with a census of 72 the day of survey. Findings include: Observation on 03/31/10 at 10:25 a.m. revealed the exit corridor from the rehab and therapy department was being used as a storage area for deliveries. The corridor was the main entrance and exit from the resident therapy and rehab room. The corridor had several boxes of supplies stored in the egress corridor from approximately 10:25 a.m., through 1:30 p.m. The corridor was eight feet wide without alcoves. Interview with the Maintenance Supervisor on 03/31/10 at 10:25 a.m. revealed that he thought that it was permitted to store deliverables in a service corridor and did not realize the corridor was a required emergency exit egress corridor from the rehab and therapy department. The census of 72 was verified by the Administrator on 03/31/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit	K 027 K 039	*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 039 This will be met as evidenced by: a. Supplies placed in the egress corridor from the rehab and therapy department will be moved to provide the required emergency exit egress. b. On an ongoing basis, items placed in exit corridors will be removed in 30 minutes or less to maintain the required emergency exit egress in all exit corridors. c. The Maintenance Director/Designee will make routine facility rounds to determine that emergency exit egress requirements are met in exit corridors. d. Results of facility rounds will be presented by the Maintenance Director/Designee to the Safety PI Committee for review and further action if indicated.	5/10/10

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K 039	Continued From page 3 interview on 03/31/10. Actual NFPA Standard: NFPA 101, 19.2.3.3*. Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of non-ambulatory persons carried on stretchers or on mattresses serving as stretchers. Actual NFPA Standard: NFPA 101, 7.3.4.2. Where a single exit access leads to an exit, its capacity in terms of width shall be not less than the required capacity of the exit to which it leads. Where more than one exit access leads to an exit, each shall have a width adequate for the number of persons it accommodates.	K 039	*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 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a properly maintained and installed fire alarm system. The deficient practice would affect all eight smoke compartments of the	K 062	K 052 This will be met as evidenced by: a. In the nine cited areas, smoke detectors will be moved to meet the NFPA Standards as related to the positioning of smoke detectors in the vicinity of air supply diffusers and/or return air openings. b. All smoke detectors will be positioned in compliance with NFPA Standards as related to the positioning of detectors in the vicinity of air supply diffusers and/or return air openings. c. Maintenance Director/Designee will monitor future changes to	5/10/10

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K 052	Continued From page 4 facility, staff and residents. The facility has the capacity for 88 beds with a census of 72 the day of survey. Findings include: Observation on 03/31/10 at 1:15 p.m. during the inspection and testing of the facility fire alarm system it was observed throughout the facility that a new HVAC system with new duct work and registers for supply and return had been installed. The new supply and return registers were installed less than three feet from existing smoke detectors and in some cases next to a smoke detector. The new registers were located next to existing smoke detectors in all smoke compartments in the facility at nine different locations. Interview with the facility Maintenance Supervisor revealed the facility was not aware the HVAC contractor had installed supply and return registers next to the existing fire alarm smoke detectors. The census of 72 was verified by the Administrator on 03/31/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/31/10. Actual NFPA Standard: NFPA 72, 2-3.6.6.2. Smoke detectors shall not be located directly in the airstream of supply registers. Actual NFPA Standard: NFPA 72, 2-3.5.1*. In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Actual NFPA Standard: NFPA 72, A-2-3.5.1. Detectors should not be located in a direct airflow or any closer than 3 ft (1 m) from an air supply	K 052	*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.* determine that compliance is maintained. d. Any concerns will be referred to the PI Safety Committee for review and indicated actions.	

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K 052	Continued From page 5 diffuser or return air opening. Supply or return sources larger than those commonly found in residential and small commercial establishments can require greater clearance to smoke detectors. Similarly, smoke detectors should be located farther away from high velocity air supplies.	K 052	*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 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 observation and interview, the facility failed to maintain the Emergency Power Supply System (EPSS) that would start and transfer emergency power to the facility in ten seconds or less and failed to provide a remote alarm for the emergency generator at a work site where it would be readily observable by personnel. The deficient practice would affect eight of eight smoke compartments, all residents and staff. The facility has the capacity for 88 beds with a census of 72 the day of survey. Findings include: 1. Observation on 03/31/10 at 2:10 p.m., during an emergency generator start and transfer test performed by the Maintenance Supervisor, the generator started but the transfer panel took 23	K 144	K 144 This will be met as evidenced by: a. Required work will be completed on the EPSS to assure that it will start and transfer emergency power to the facility in 10 seconds or less. b. An enunciator panel will be installed by the front nurses station to provide the required remote alarm panel in a readily observable location. c. The Maintenance Director/Designee will complete required PM activities to determine that the generator starts and emergency power is transferred within required time frames and will monitor the enunciator panel to determine correct function. d. Any trends/concerns will be presented to the PI Safety Committee for review and recommendations if indicated.	5/10/10

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K 144	Continued From page 6 seconds to transfer the emergency power to the facility. Interview with the Maintenance Supervisor on 03/31/10 at 2:10 p.m. revealed that the facility was not aware it was taking 23 seconds for the EPSS to start and transfer the electrical service to emergency power. 2. Observation during the inspection and testing of the emergency generator on 03/31/10 at 2:15 p.m. revealed that the newly installed emergency generator system did not have a remote audible alarm panel located at a readily observable location. Interview with the facility Maintenance Supervisor on 03/31/10 at 2:15 p.m. revealed the contractor had been notified and was to finish the installation with the remote alarm panel. The census of 72 was verified by the Administrator on 03/31/10. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/31/10. Actual NFPA Standard: NFPA 99, 3-4.4.1.1 (a). The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within a 10-second interval. Actual NFPA Standard: NFPA 99, 3-4.4.1.1 (b) 2. The scheduled generator test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. Actual NFPA Standard: NFPA 110, 3-5.6.1. A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2(d). This remote alarm shall be located outside of the EPS service room at a work site	K 144		

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K 144	Continued From page 7 readily observable by personnel.	K 144		