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	02/24/2015

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 Stories: 1 Construction: Type II(000) Constructed: 1982 K0180: Fully Sprinkled Certified Beds: 90 Capacity: 75 Census: 70	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to mark the means of egress as required. Findings include: On 2/24/15 there was an exit sign above the secured unit south core area. As the door was locked, this was not a means of egress for the non-clinical need area where the sign was visible. Doors that can be mistaken for an exit are required to be marked, " NO EXIT "	K 022	Facility Policy It is the policy of the Wyoming Retirement Center to have all access to exits marked by approved, readily visible signs in all cases where an exit or way to reach exit is not readily apparent to the occupants. Corrective Action On March 23, 2015, a "No Exit" sign was mounted on the door to the secured unit south core area. Prevention The WRC maintenance personnel will educate employees on the reason for this sign. Also, the maintenance department will inspect other exit doors in the facility to ensure compliance with the NFPA. Compliance Monitoring The Environmental Services Manager or designee will have maintenance personnel produce a report on the exit doors that may need signs. This will be completed once a month for the next three months. The Environmental Service Manager will report her findings for the next three months to the QAPI committee. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.	03/23/15

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

NHA | 3-30-15

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 000	INITIAL COMMENTS Stories: 1 Construction: Type II(000) Constructed: 1982 K0180: Fully Sprinkled Certified Beds: 90 Capacity: 75 Census: 70	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to mark the means of egress as required. Findings include: On 2/24/15 there was an exit sign above the secured unit south core area. As the door was locked, this was not a means of egress for the non-clinical need area where the sign was visible. Doors that can be mistaken for an exit are required to be marked, " NO EXIT "	K 022	Facility Policy It is the policy of the Wyoming Retirement Center to have all access to exits marked by approved, readily visible signs in all cases where an exit or way to reach exit is not readily apparent to the occupants. Corrective Action On March 23, 2015, a "No Exit" sign was mounted on the door to the secured unit south core area. Prevention The WRC maintenance personnel will educate employees on the reason for this sign. Also, the maintenance department will inspect other exit doors in the facility to ensure compliance with the NFPA. Compliance Monitoring The Environmental Services Manager or designee will have maintenance personnel produce a report on the exit doors that may need signs. This will be completed once a month for the next three months. The Environmental Service Manager will report her findings for the next three months to the QAPI committee. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.	03/23/15

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K 022	Continued From page 1 The Maintenance Technician was present when the deficiency was identified. Failure to mark the means of egress as required increases the risk of death or injury due to fire. The deficiency affected one of numerous means of egress in the building. Ref: 2000 NFPA 101 Section 19.2.10.1, 7.10.8.1	K 022		
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 interview, the facility failed to protect hazardous areas as required. Findings include: On 2/24/15 the following storage rooms were found to have doors that were not self-closing. Storage rooms that exceed 50 sf in size and contain combustible materials are considered hazardous areas. Doors to hazardous areas are	K 029		

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K 029	Continued From page 2 required to be self-closing. · Chapel storage room- 64 sf The Maintenance Technician was present when the deficiency was identified. Failure to protect hazardous areas as required increases the risk of death or injury due to fire. The deficiency affected one of numerous locations requiring self-closing doors. Ref: 2000 NFPA 101 Section 19.3.2.1	K 029	Facility Policy (K 038) It is the policy of the WRC to have exits that are readily accessible at all times. Corrective Action On March 3, 2015, the dead bolt locks on the north common area tub room door were replaced with a door handle. The door handle is located between 32 and 48 inches above the floor.	03/02/15
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 interview, the facility failed to maintain the means of egress as required. Findings include: On 2/24/15 releasing mechanisms for doors at the following location were not installed at the required height: · North common showers: dead bolt at 60 inches above floor · IT room, Deadbolt at 61 inches Releasing mechanisms for locks and latches on	K 038	On March 3, 2015, the dead bolt lock on the IT door was lowered to 32 to 48 inches above the floor. On March 3, 2015, the north vestibule module key locks were removed and replaced with "blanks". On March 2, 2015, the Activities inside hasp on the bathroom door was removed and the hasp on the inside door of the PT room was removed. *The WRC contacted a contractor, API, to remove the "double lock" feature on the stair way door. Also, to devise a system to ensure t he residents are safe when the lock is removed from the North Unit Pod. The WRC has asked for a time limited waiver to complete these projects by June 1, 2015.	03/02/15

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	535021	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/24/2015**

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WYOMING RETIREMENT CENTER	**890 US HWY 20 SOUTH** **BASIN, WY 82410**

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K 038	Continued From page 3 doors are required to be located between 32 and 48 above the floor. Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 On 2/24/14 the following doors were found be equipped with keyed locks in the direction of egress. Doors in the means of egress are not permitted to be equipped with a lock or latch that requires the use of a key in the direction of egress. · Vestibule north module · Exit discharge gate for non-clinical need area North C pod Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4 On 2/24/14 the following doors were equipped with two locking/ latching devices where two releasing operations were required to operate the door. Doors in the means of egress are required to be operable with not more than one releasing operation. · Activities PT areas- slide hasps on both doors. At least one needs to be compliant. Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 On 2/24/14 the following doors were equipped with locks that required operation of a " push to exit " button located adjacent to the door. Doors are required to be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side. The "push to exit" lock does not meet this requirement. If these doors are intended to be secured access doors, they are required to have a motion sensor that release the door in the direction of egress in addition to the existing door release switch.	K 038	Prevention The WRC personnel have been trained on the necessity to follow the door handle measurements and the reason why locks cannot be on certain doors and hasps within t he facility. Compliance Monitoring The Environmental Service Manager or designee will perform spot checks on doors in the facility to ensure compliance with door handle measurements and hasps on doors. This will be done once a month for the next three months. The Environmental Service Manager will report her findings for the next three months to the QAPI committee. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.	

Facility Policy (K 046)

03/23/15

It is the policy of the WRC to provide emergency lightening as required.

Corrective Action

An emergency light test was conducted for 90 minutes on March 23, 2015. The maintenance policy and procedure manual has been updated to reflect this NFPA Life Safety Code Standard.

Prevention

It will be the responsibility of the maintenance personnel to conduct and document the annual testing of the emergency lighting for the 90 minute testing interval. A testing log has been implemented to ensure documentation of the testing.

Compliance Monitoring

The Environmental Services Manager or designee will monitor compliance/documentation of the annual 90 minute test interval of the emergency lighting.

The Environmental Service Manager will report her findings once a month for the next three months to the QAPI committee. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.

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K 046	Continued From page 5 The deficiency affected two of numerous requirements of the emergency lighting system. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3	K 046	Facility Policy (K 048) It is the policy the WRC to have a fire plan that includes the evacuation of smoke compartments.	
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a fire plan as required. Findings include: On 2/24/15 the fire plan did provide for evacuation of smoke compartment as required. The Maintenance Technician was present when the deficiency was identified. Failure to provide a fire plan as required increases the risk of death or injury due to fire. The deficiency affected one of eight required components of a fire plan.	K 048	Corrective Action On March 23, 2015, the WRC RACE procedure was updated to include the evacuation of smoke compartments. Prevention The Environmental Services Manager or designee will ensure all RACE procedure manuals are updated. The WRC staff will be trained on this procedure and have sign in sheets to support the documentation of this training. Compliance Monitoring The Environmental Service Manager will give updates on the training and updated procedures to the QAPI committee for the next three months. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.	03/23/15 03/03/15
K 062 SS=D	Ref: 2000 NFPA 101 Section 19.7.1.1, 19.7.2.2 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	Facility Policy (K 062) It is the policy of the WRC to have ceiling tiles to prevent smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. Corrective Action	

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K 062	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system as required. Findings include: On 2/24/15 ceiling tiles in the following rooms were missing or incomplete. The tiles are a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such they are required to be maintained. · Glycol room at front entry The Maintenance Technician was present when the deficiency was identified. Failure to maintain the sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous locations protected with sprinklers. Ref: 2000 NFPA 101 Section 4.6.12.1	K 062	On March 3, 2015 the Glycol ceiling tile was replaced in the storage room in front entry of the building. Prevention Facility staff will be re-trained on the importance of the Glycol ceiling tiles. All personnel will be informed to monitor f or missing tiles and to notify the maintenance department immediately if an area is found with a missing Glycol tile(s). Compliance Monitoring The Environmental Service Manager or designee will monitor once month for the next three months for missing Glycol tiles. These findings will be submitted to the QAPI committee who will monitor for compliance and will suggest future frequency of audits as success is demonstrated. Facility Policy (K 074) It is the policy of the WRC to have draperies, curtains, cubicle curtains, loosely hanging fabrics, films servings as furnishings or decorations to have the tag meeting the flame resistance NFPA requirement.	03/23/15
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.	K 074		

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K 074	Continued From page 7 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 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 interview, the facility failed to provide curtains with the proper qualities. Findings include: On 2/24/15 curtains were identified in the following locations that were not tagged as meeting flame resistance requirement. · Room 320- exterior windows 2 each The Maintenance Technician was present when the deficiency was identified. Failure to increases the risk of death or injury due to fire. The deficiency affected one of numerous rooms in the building. Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1	K 074	Corrective Action On March 23, 2015 the curtains identified as not have the flame resistance tag in room 20 were removed and replace with curtains that have the flame resistance tag. Prevention The Housekeeping/facility personnel will monitor draperies, curtains, cubicle curtains, loosely hanging fabrics, films servings as furnishings or decorations to have the tag meeting the flame resistance NFPA requirement. Facility staff will be re-trained on this policy. Compliance Monitoring The Housekeeping personnel will perform room audits to ensure all draperies, curtains, cubicle curtains, loosely hanging fabrics, films servings as furnishings or decorations. This will be documented once a month for for next three months and housekeeping log for three months. The Environmental Service Manager will give updates on the training and updated procedures to the QAPI committee for the next three months. The frequency thereafter will be determined by the QAPI committee as compliance is monitored.	