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

PRINTED: 04/06/2015
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
	535051	A. BUILDING 02 - MAIN BUILDING B. WING	03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

(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 sprinklered, 1-story building of Type V (000) construction built in 1954 with additions of the same construction type built in 1985 and 1990. The building was equipped with a supervised, automatic wet sprinkler system and a zoned fire alarm system. The facility has 60 certified Medicare and Medicaid beds with a census of 47.	K 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of the deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was taken.	05/10/15
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.	K 018	1. The facility will provide doors that resist the passage of smoke in 4 of 4 smoke compartments. 2. All residents are affected. 3. On 3/24/15 the facility repaired the latching mechanism on Resident Room #11 ensuring that the door would keep closed into the frame. Maintenance staff will be in-serviced on 2000 NFPA 101, Section 19.3.6.3 that all doors in sprinklered buildings are required to resist the passage of smoke and that there be no impediment to the closing of doors. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — NHA — Administrator — (X6) DATE 4/16/15

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.

POC Accepted V.A Phone Call with Administrator Todd Homi on 4/24/15 at 9:23 AM 34354

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors that resisted the passage of smoke in 1 of 4 smoke compartments. The findings were: Observation of Resident Room #11 on 03/23/15 at 4:25 PM revealed that latching mechanism on the door would not keep the door closed into the frame. At the time of the observation, the Facility Maintenance Manager acknowledge the door would not stay closed in the frame. Ref: 2000 NFPA 101, Section 19.3.6.3.2	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	1. The facility will provide protection of hazardous areas from adjacent corridors and non-hazardous rooms in 4 of 4 smoke compartments. 2. All residents are affected. 3. On 3/24/15 all door stops blocking doors open to the Laundry Room, Linen Room and Dryer Room were removed. Maintenance/Housekeeping staff will be in-serviced on 2000 NFPA 101, Section 7.2.1.8.1 that doors to hazardous area enclosures be held open only by devices arranged to automatically close.	05/10/15

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K 021	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide protection of hazardous areas from adjacent corridors and non-hazardous rooms in 1 of 4 smoke compartments. The findings were: Observation of the Facility Laundry Rooms on 03/24/15 from 8:25 AM to 8:27 AM revealed that the Laundry Room, Linen Room, and the Dryer Room all had self-closing devices installed on the doors. Further observation revealed that all three doors were blocked open with door stops. At the time of the observations, the Facility Maintenance Manager acknowledged the doors blocked open. Ref: 2000 NFPA 101, Section 7.2.1.8.1	K 021	4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	
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 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	K 029	1. The facility will ensure that hazardous areas be protected from the corridor with self-closing doors in 4 of 4 smoke compartments. 2. All residents are affected. 3. The facility will install self-closing devices on the Central Supply Storage Room, the Storage Room on D hallway and on the kitchen door. Maintenance staff will be in-serviced on 2000 NFPA 101, Sections 19.3.2.1 and 5.3.15.2 that	05/10/15

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 3 of 4 smoke compartments. The findings were: 1. Observation of the Central Supply Storage Room on 03/23/15 at 4:17 PM revealed the room was greater than 50 sq feet and was not supplied with a self-closing door. At the time of the observation, the Facility Maintenance Manager acknowledge the room was not provided with a self-closing door. 2. Observation of the Storage Room on D hallway on 03/23/15 at 5:05 PM revealed the room was greater than 50 sq feet and was not supplied with a self-closing door. At the time of the observation, the Facility Maintenance Manager acknowledge the room was not provided with a self-closing door. 3. Observation of the Kitchen door to the corridor on 03/23/15 at 5:20 PM revealed the kitchen was a hazardous area and was not supplied with a self-closing door. At the time of the observation, the Facility Maintenance Manager acknowledge the room was not provided with a self-closing door. Ref: 2000 NFPA 101, Sections 19.3.2.1 and 8.3.13.2	K 029	hazardous areas be protected from the corridor with self-closing doors. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	
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	K 038	1. The facility will arrange exit access so that exits are readily accessible at all times.	05/10/15

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access to that exits are readily accessible at all times. The findings were: 1. Observation of the Delayed Egress Exit on A Hall on 03/23/15 at 3:55 PM revealed that approximate 6 seconds of continuous pressure of 15lbf was required in lieu of the required 3 seconds to start the irreversible process of releasing the locking mechanism. At the time of the observation, the Facility Maintenance Manager acknowledged the additional time needed to start the releasing process. 2. Observation of the Delayed Egress Exit on B Hall on 03/23/15 at 4:10 PM revealed that approximate 5 seconds of continuous pressure of 15lbf was required in lieu of the required 3 seconds to start the irreversible process of releasing the locking mechanism. At the time of the observation, the Facility Maintenance Manager acknowledged the additional time needed to start the releasing process. 3. Observation of the Delayed Egress Exit in the Secured Unit adjacent to the double doors leading to the Unsecured Unit on 03/23/15 at 5:03 PM revealed the delayed egress hardware required more than 15lbf to activate the release process. At the time of the observation, the Facility Maintenance Manager Acknowledged the doors required more than the required 15lbf to	K 038	2. All residents are affected. 3. The required 3 seconds of 15lbf of pressure will start the irreversible process of releasing the locking mechanism on Delayed Egress Exits on A Hall and B Hall. No more than 15lbf of continuous pressure will be required to activate the release process on the Delayed Egress Exit in the Secured Unit adjacent to the double doors leading to the Unsecured Unit as well as the Delayed Egress Exit in the Dining Room. Door locks that require no special knowledge or effort for operation from the egress side will be installed in the Physical Therapy Room, Room #14, Social Services bathroom, Social Services corridor door, Beauty Salon, Soiled Utility Room in the Secured Unit and the Nurse Storage Room in the basement. Sensor will be provided on the egress side of the Secured Unit to detect an occupant approaching the doors and unlock the doors in the direction of egress. Also, a manual release device labeled "Push to Exit" will be installed. Staff will be in-serviced on 2000 NFPA 101, Sections 19.2.2.2.1, 7.2.1.6.1(c), 7.2.1.5.1 and 7.2.1.6.2 that exit access be arranged so that exits are readily accessible at all times. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	

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K 038	Continued From page 5 release the doors. 4. Observation of the Delayed Egress Exit in the Dining Room on 03/23/15 at 5:30 PM revealed the delayed egress hardware required more than 15lbf to activate the release process. At the time of the observation the, Facility Maintenance Manager Acknowledged the doors required more than the required 15lbf to release the doors. 5. Observation of the following locations on 03/23/15 from 4:30 PM to 5:30 PM revealed door locks that required special knowledge or effort for operation from the egress side. The Physical Therapy Room, Room #14, Social Services bathroom, Social Services corridor door, Beauty Salon, Soiled Utility Room in the Secured Unit, and the Nurse Storage Room in the basement observed on 03/24/15 at 8:20 AM. 6. Observation of the doors into the Secured Unit on 03/23/15 at 4:55 PM revealed that the doors were not provided with a sensor on the egress side to detect an occupant approaching the doors and that the doors would not unlock in the direction of egress. Further observation revealed that no manuel release device was provided labeled "Push to Exit". At the time of the observation, the Facility Maintenance Manager, and the Facility Administrator both acknowledged that a sensor and manual release device were not provided for the door. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.6.1(c) 2000 NFPA 101 Sections 7.2.1.5.1 and 7.2.1.6.2	K 038		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		

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K 046 SS=D	Continued From page 6 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation identifying a maintenance policy of the emergency lighting system. The findings were: Document review and staff interview of the testing and maintenance documentation on 03/24/15 from 8:45 AM to 10:00 AM revealed documentation was not made available during the survey to indicate that the required 90 minute annual testing of the emergency lighting had been performed. Interview with the Facility Maintenance Manager and the Facility Administrator confirmed that the required testing had not been completed. Ref: 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3	K 046	1. The facility will provide documentation identifying a maintenance policy of the emergency lighting system. 2. All residents are affected. 3. Documentation will be kept and made available indicating that the required 90 minute annual testing of the emergency lighting has been performed. Maintenance staff will be in-serviced on 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3 concerning emergency lighting, testing and documentation thereof. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	
K 052 SS=D	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	K 052	1. The facility will provide documentation that the fire alarm system has been tested in accordance with NFPA 72. 2. All residents are affected. 3. The facility will ensure that the fire alarm system is activated and tested monthly and that documentation is made thereof. Maintenance staff will be in-serviced on 2000 NFPA 101, Section 9.6.1.4 and 1999 NFPA 72, Table 7-3.2	5/10/15

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K 052	Continued From page 7 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation that the fire alarm system had been tested in accordance with NFPA 72. The findings were: Document review and staff interview of the Fire Alarm System on 03/24/15 from 8:35 AM to 10:00 AM revealed that documentation was not available at the time of the survey to demonstrate that the fire alarm had been activated monthly. Activation could not be established for the months of September and December of 2014 and for the month of March 2015. At the time of the review, the Facility Maintenance Manager acknowledged the alarm had not been activated in these months. Ref: 2000 NFPA 101, Section 9.6.1.4 1999 NFPA 72, Table 7-3.2 (23)	K 052	(23) that fire systems must be tested and activated monthly and that documentation is made thereof. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	
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 This STANDARD is not met as evidenced by: Based on observation, document review, and facility staff interview, the facility failed to maintain	K 062	1. The facility will maintain sprinkler systems in a reliable operating condition. 2. All residents are affected. 3. The facility will provide a hydraulic design information sign at the riser. Maintenance staff will be in-serviced on 1999 NFPA 13 section 10-5 that fire riser hydraulic information must be provided at the riser.	5/10/15

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K 062	Continued From page 8 sprinkler systems in a reliable operating condition. The finding were: Observation of the fire riser on 03/24/15 at 8:35 AM revealed no hydraulic design information sign was provided at the riser. At the time of the observation, the Facility Manager acknowledged the missing hydraulic information. Ref: 1999 NFPA 13 section 10-5	K 062	4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	
K 144 SS=D	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 document review and staff interview, the facility failed to ensure weekly maintenance inspections were being performed for the generator. Document review and staff interview on 03/24/15 from 8:45 AM to 10:00 AM revealed that no records were available for the weekly inspections. Interview with the Facility Maintenance Manager at the time of the review acknowledged the documentation was not present. Ref:	K 144	1. The facility will ensure that weekly maintenance inspections are being performed for the generator. 2. All residents are affected. 3. Weekly maintenance inspections will be performed for the generator and documentation made thereof. Maintenance staff will be in-serviced on 1999 NFPA 99, Section 3-4.4.1.1 and 1999 NFPA 110, Section 6-4.1 that weekly maintenance inspections of the generator be performed weekly and documentation made thereof. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Findings to QA monthly. 5. Completed by 5/10/15.	5/10/15

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K 144	Continued From page 9 1999 NFPA 99, Section 3-4.4.1.1 1999 NFPA 110, Section 6-4.1	K 144		