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

PRINTED: 02/18/2009
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 _____	02/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABI	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	POC Accepted w/ Exhibit D2D, NHA, on 3/16/09. *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 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 staff interview the facility failed to ensure the recurred means of egress headroom in one of six smoke compartments. The findings were: Observation on 2/03/09 between 8 AM and 9 AM revealed the egress double doors to the special care unit (SCU) and main entrance were equipped with magnetic hold open devices that did not have the required six foot eight inch headroom. The measurement from the floor to the bottom of the magnetic devices were 6 ft. 4 in. 2. Interview with the maintenance director on 2/03/09 at 8:06 AM revealed he was aware of the	K 038	K 038 This standard will be met as evidenced by: 1. Magnetic devices on egress double doors to the Special Care Unit and main entrance will be re-aligned to provide maximum headroom allowed by frames. 2. Other egress doors will be assessed by the Maintenance Department to assure compliance with required egress standards. 3. Maintenance Department will check and document all concerns related egress door compliance. 4. The Environmental Services Director will report any concerns noted to the Performance Improvement Committee for review and further actions if indicated. **RECEIVED** **Wyoming Dept of Health** MAR 0 5 2009	3/20/2009

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec. Director — **Office of Healthcare Licensing and Survey** — (X6) DATE: 2/28/09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 038	Continued From page 1 headroom requirements for egress areas. He stated the corporate office had informed the facility of the problem, but had not yet provided a solution.	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 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 052 SS=E	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 staff interview the facility failed to ensure the central station certificate was current and failed to ensure magnetic hold open devices on 4 of 10 smoke barrier doors released when the fire alarm system was activated. The findings were: 1. Observation on 2/02/09 at 4:42 PM revealed the central station placard expired on 3/31/08. Interview with the maintenance director at the time of observation revealed he was unaware it had expired. The facility did not have a current certificate. 2. Observation on 2/03/09 at 10:28 AM revealed the fire alarm system was activated during a fire drill. The alarms were silenced so overhead	K 052	K052 This standard will be met as evidenced by: 1. Central station placard with expiration date of 03/31/2009 will be posted per Requirements. Door magnet system will be corrected by Simplex Grinnell to remain demagnetized until the fire alarm system is reset following an alarm. 2. ESD will assure central station placard is kept current. 3. Door magnet system will be checked by the ESD/Designee for proper function at each fire drill, utilizing a performance improvement audit tool. 4. The ESD/Designee will report results of PI audit to the Performance Improvement Committee on a quarterly basis for review and further intervention, if indicated.	3/20/09

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K 052	Continued From page 2 instruction were easier to hear. During this time the magnetic hold open devices associated with the double smoke barrier doors near resident rooms #29 and #7 were inspected. The magnetic devices were re-energized with the silencing of the alarm; therefore, they did not function as required. Interview with the maintenance director at the time of observation revealed the magnetic hold open devices were not routinely inspected.	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 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure space heaters were prohibited in resident sleeping rooms in one of six smoke compartments. The findings were: Observation on 2/02/09 at 3:36 PM revealed a portable space heater was in use in resident room # 32. Interview with the maintenance director at the time of observation revealed he was unaware portable space heaters were prohibited in resident sleeping rooms.	K 070	K070 This standard will be met as evidenced by: 1. Portable space heater will be removed from Room #32. 2. Family education and routine rounds by maintenance staff will assure portable space heaters are not used in resident sleeping rooms. 3. A performance improvement audit tool will be utilized by the ESD/Designee to check resident sleeping rooms for presence of portable heaters. Any heaters found will be removed. 4. Results of the PI audits will be presented to the Performance Improvement Committee on a quarterly basis for review and further actions, if indicated.	3/20/2009
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 This standard will be met as evidenced by: 1. Exposed wires to the delayed egress lock on the Special Care Unit door will be placed in insulated covering with no exposure to the	3/20/2009

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure electrical wires were not damaged in one of six smoke compartments. The findings were: Observation on 2/03/09 at 8:24 AM revealed the electrical wires to the delayed egress lock on the special care unit (SCU) exterior door had exposed wires. The outer sheet of the cord had been peeled back and three wires were exposed. Interview with the maintenance director at the time of observation revealed the egress locks were inspected weekly, but the electrical wire was not examined routinely.	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 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 147 Continued from Page 3 outside. 2. Maintenance Director/Designee will assure all potentially exposed wires remain enclosed in insulated coverings. 3. Maintenance Director/Designee will complete routine rounds to assure electrical wires are not exposed. Results of rounds will be documented By the Maintenance Director/Designee, utilizing a PI audit tool. 4. Results of the audit will be presented to the Performance Improvement Committee by the ESD on a quarterly basis for review and further interventions, if indicated.	
K 161 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure only one dumbwaiter door could open at a time in two of six smoke compartments. The findings were: Observation on 2/03/09 at 9:50 AM revealed the first floor door to the dumbwaiter was open while the basement door was also open. With both doors open at the same time the shaft was not 1-hour fire rated. Interview with the maintenance director at the time of observation revealed he was aware that both doors were not supposed to be open at the same time. He stated that his corporate office was working on a solution, but	K 161		

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K 161	Continued From page 4 they had not yet provided him with one.	K 161	*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 161 This standard will be met as evidenced by: 1. Door closures for the dumbwaiter system will be repaired in a manner that allows one door to open at a time. 2. Laundry and nursing staff utilizing the dumbwaiter will routinely check to assure only one door is open when using. 3. The ESD/Designee will utilize a PI audit tool to routinely check the dumbwaiter door functions to assure only one door can open at a time. 4. The ESD/Designee will report results of the audit tool to the Performance Improvement Committee on a quarterly basis to review and further actions, if indicated.	3/20/2009