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

PRINTED: 07/05/2016
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
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

(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 Nursing Homes Section 42 CFR 416.44 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing and New Health Care, and New Ambulatory Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, one-story building of Type V (111) construction built in 1965. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had 5 smoke compartments. The facility had a capacity of 62 certified Medicare and Medicaid beds with a census of 46.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 staff interview, the facility failed to ensure hazardous areas were protected from the corridor by smoke resisting partitions and doors. The findings were: 1. Observation on 05/17/2016 at 12:23 PM in an adjacent space next to and open to the corridor	K 029	K-029: Corrective action-items in adjacent space next and open to the corridor were removed 5/23/16. Identification of others: Full building inspection completed to ensure no other hazardous were unprotected to the	6/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Dennis Bland — TITLE: Executive Director — (X6) DATE: 08/08/2016

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.

WY Dept of Health
JUL 20 2016
Healthcare Licensing and Surveys

POC has been accepted + called Dan Stachous informing him of acceptance 7-25-2016

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K 029	Continued From page 1 next to room 11 revealed that the space was being utilized for storage. Further observation revealed a curtain not capable of restricting smoke was present to separate the space from the corridor. At the time of the observation the Facility Maintenance Manager acknowledged that the curtain was not equivalent to a smoke partition.	K 029	corridor. Systemic changes: No hazardous or unprotected areas will be open to areas. Monitoring: Maintenance director/designee will conduct weekly rounds to ensure hazardous areas are protected from corridor and report results to QI committee every month for three months.	
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 arrange exit access so that exits are readily accessible at all times. 1. Observation on 05/17/2016 at 12:20 PM in the Beauty Salon room revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 2. Observation on 05/17/2016 at 12:27 PM located at the storage closet next to room 23 revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of	K 038	K-038: Corrective action- Door locks identified changed to single action locks. Identification of others: Full building inspection completed, no other locks identified as having more than one releasing operation. Systemic changes: All lock replacement needed or ordered will be single action locks. Monitoring: Maintenance Director/designee will conduct weekly rounds to ensure facility locks are single action locks and will report to QAPI committee for determination of ongoing monitoring.	6/22/16

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K 038	Continued From page 2 the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 3. Observation on 05/17/2016 at 12:57 PM located at housekeeping room adjacent to physical therapy room revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 4. Observation on 05/17/2016 at 1:05 PM located at the break room next to physical therapy office in the bathroom revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the exit access. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 5. Observation on 05/17/2016 at 1:07 PM located at rehab room revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of the observation the Facility	K 038		

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K 038	Continued From page 3 Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 6. Observation on 05/17/2016 at 1:12 PM located at kitchen door and dishwashing door revealed the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 7. Observation on 05/17/2016 at 1:15 PM located at the basement bathroom revealed that the door lock required tight pinching, and more than one releasing operation to make the door operable to the corridor. At the time of the observation the Facility Maintenance Manager acknowledged the door lock required more than one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide battery-powered emergency lighting for their generator. The	K 130	K-0130 Corrective action- A battery powered emergency lighting fixture has been ordered to be used for generator	6/22/16

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K 130	Continued From page 4 findings were: Observation on 05/17/2016 at 1:54 PM of the generator area outside revealed there was no battery-powered emergency lighting for the generator. At the time of the observation the Facility Maintenance Manager acknowledged that their was no batter-powered emergency lighting in the generator area.	K 130	area. 5/23/16 Identification of others: No other on-site generators. Systemic Changes: Installation of battery powered light fixture for generator area. Once fixture has been installed it will be tested monthly.	