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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single story building with a partial basement. Type V(111) construction built in 1965. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 81 certified Medicare and Medicaid beds with a census of 70.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced	K 131		12/1/17

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

Electronically Signed | 11/27/2017

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.

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 131	Continued From page 1 by: Based on observation and interview the facility failed to maintain a 2-hour separating wall in accordance with the 2012 NFPA 101 LSC. The findings were: Observation on 11/07/17 at 1:00 PM revealed that the 2-hour fire resistance barrier separating the Kitchen and Rehabilitation areas from the remainder of the building had unproperly protected plumbing penetrations and electrical wire penetrations in the attic. Failure to properly protect all penetration could lead to injury or death by propagation of smoke or fire through the wall. Interview with the maintenance director at the time of the observation revealed that they were aware of the requirements for protection of penetrations of fire barriers but were unaware of the penetrations in the wall. Reference: 2012 NFPA 101 19.1.3.5, 8.3.5.1	K 131	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis of the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Corrective Actions Electrical and plumbing penetrations filled with fire caulking on 11/24/17 by Executive Director and Maintenance Manager. Identification of Others ED and Maintenance manager inspected fire barriers in attic for unprotected wall penetrations. One other penetration was found without proper protection and was filled in on 11/24/17. Systemic Changes ED/designee educated maintenance director on preventative maintenance to check for penetrations on 11/24/17. Satisfactory work to have photo evidence recorded and stored in the preventative maintenance binder for reference. Maintenance director will incorporate into preventative maintenance program.	

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 131	Continued From page 2	K 131	Monitoring for Compliance Photos to be taken of completed work at time of start and at time of completion to show proper fire protection. Photos of the new repairs shall be brought to the QAPI meeting monthly.	
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the means of egress in accordance with the 2012 NFPA Life Safety Code. The findings were: 1. Observation on 11/07/17 at 11:46 AM revealed that a door to the exterior in the employee lounge was labeled "Not An Exit" which does not meet the requirements of the LSC for a sign on a door that is neither an exit nor a way of exit access. Failure to provide the correct signage for means of egress could result in injury or death in the event of an emergency. Interview with the maintenance director at the time of the	K 200	Corrective Actions New signage posted on 11/22/2017 by Executive Director. New signage is compliant with 2012 NFPA 101 19.2.1, 7.10.8.3.1 on door leading from employee lounge to enclosed courtyard. New equipment ordered fire rated panic push bar installed by ED and Maintenance director on 12/5/2017. Identification of Others One other door identified without signage compliant to leading from main dining room to enclosed courtyard. Proper	12/5/17

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 200	Continued From page 3 observation revealed that the facility was unaware of the exact language required for no exit signs. Ref: 2012 NFPA 101 19.2.1, 7.10.8.3.1 2. Observation on 11/07/17 at 12:45 PM revealed that the 1-1/2 hour doors at the 2 hour fire resistance barrier were provided with panic hardware in lieu of the required fire exit hardware. Failure to provide proper fire exit hardware could result in failure or death by hardware not operating properly. Interview with the maintenance director at the time of the observation revealed that they were unaware the hardware installed on the door was not fire exit hardware. Reference: 2012 NFPA 101 19.2.2.2.1, 7.2.1.7.2	K 200	signage posted 11/22/2017 that says, No Exit. Center only has one set of fire doors. Systemic Changes Replacement doors to have photo evidence recorded showing compliance and kept in preventative maintenance binder. Replacement of non-egress doors to courtyard in future to have similar signage. Documentation of fire rated panic equipment on fire doors to be kept in preventative maintenance binder. ED educated maintenance director on required signage for door leading to on 11/24/17. ED educated maintenance director on required hardware for fire doors on 11/24/17. Monitoring for Compliance Photos to be taken of completed work at time of start and at time of completion to show proper signage. Photos to be taken of completed work at time of start and at time of completion to show proper fire protection of panic equipment on fire doors.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		12/1/17

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 353	Continued From page 4 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to test the fire sprinkler system in accordance with 2011 NFPA 25 Standard for Inspection, Testing, and Maintenance Water-Based Fire Protection System: The findings were: Documentation review at the time of the survey on 11/07/17 at 1:30 PM revealed that documentation of the required annual testing of the fire sprinkler backflow preventer was unavailable. Failure to properly test the fire sprinkler system could result in injury or death in the event of an emergency. Interview with the maintenance director at the time of the documentation review revealed that they were unaware of required testing of the backflow preventer, but believed their fire sprinkler contractor was conducting the testing. Reference: 2011 NFPA 25 13.6.2.1	K 353	Corrective Actions Backflow preventer tested on 11/10/2017 by fire prevention contractor. Identification of Others Center only has one backflow preventer. Systemic Changes Fire sprinkler inspectors to include backflow testing as part of inspection annually as part of preventative maintenance program. ED educated on maintenance director on 11/24/17 for annual backflow preventer testing to be done. Monitoring for Compliance Will note testing in preventative maintenance binder annually. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 511	Continued From page 5	K 511		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide electrical equipment in accordance with the 2012 NFPA 101 and the 2011 NFPA 70. The findings were: Observation on 11/07/17 at 12:25 PM revealed that the clean utility room adjacent to resident room 15 had storage being kept within 36" of electrical panels. Failure to provide clearance to the electrical panels could result in injury or death if access is restricted in the event of an emergency. Interview with the maintenance director at the time of the observation revealed they were unaware that housekeeping items were being stored next to the electrical panels. Reference: 2012 NFPA 101 19.5, 9.1.2, 2011 NFPA 70 110.26 (A)	K 511	Corrective Actions Cart moved away from breaker box during inspection by maintenance director. Area around breaker box to have red border placed thirty-six inches in front of breaker box to show area to be kept clear by 11/27/2017. Identification of Others Will audit other breaker boxes in facility for clearance and clear area designations. All deficiencies to be fixed immediately. Facility-wide audit was conducted 11/24/17. One other location identified as obstructed. Obstruction was cleared immediately. Systemic Changes ED/designee educated staff to keep area in front of electrical panel clear of all obstructions on 11/24/17. ED/designee educated maintenance	12/1/17

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 511	Continued From page 6	K 511	director to incorporate checking electrical panel clearance into preventative maintenance program monthly on 11/24/17. Monitoring for Compliance Will conduct weekly auditing of breaker box clearance for compliance for the next three months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		12/1/17

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 923	Continued From page 7 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain oxygen storage in compliance with the 2012 NFPA 99 Health Care Facilities Code. The findings were: Observation on 11/07/17 at 11:55 AM revealed that the door to the oxygen storage room would not latch and thus negated the security code required to unlock the door. Failure to properly secure oxygen storage against unauthorized entry could result in injury or death. Interview with the maintenance director at the time of the observation revealed they were unaware that the door latch was not working but were aware of the requirement to secure the room. Ref: 2012 NFPA 101 19.3.2.4, 2012 NFPA 99 11.3.2.1	K 923	Corrective Actions Locksmith repaired door latch on 11/13/2017. Identification of Others Facility-wide audit verified other pushbutton locks in proper order showed that all other push button locks were working and latching as they were supposed to on 11/22/17. Systemic Changes Re-educated staff on notifying Maintenance director when locks not working on 11/24/17. Re-educate maintenance director on timely response to maintenance requests on 11/24/17. ED/designee educated maintenance director to implement push lock monthly testing into preventative maintenance program on 11/24/17. Monitoring for Compliance	

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 _____	**11/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	**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 923	Continued From page 8	K 923	Maintenance director to conduct random weekly audits of push button locks to verify door closing and locking.	