| 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**<br>B. WING _____ | **04/17/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **RAWLINS REHABILITATION AND WELLNESS** | **542 16TH STREET**<br>**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 |
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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on April 17, 2018.<br><br>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 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association.<br><br>The facility was a fully sprinklered, single story building with a basement 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 a capacity of 62 certified Medicare and Medicaid beds with a census of 41 residents. | K 000 | | |
| K 211<br>SS=D | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could result in injury or death during an | K 211 | 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 | 4/17/18 |

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

Electronically Signed | 05/10/2018

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| K 211 | Continued From page 1<br>emergency. The deficiency affected 1 of 7 exits. The findings were:<br><br>Observation on 4/17/2018 at 10:21 AM in the south courtyard revealed a BBQ grill in front of the exit gate, blocking exit access. The means of egress must be continuously maintained free of obstructions to allow full use in case of an emergency.<br><br>Interview with the facility maintenance director at the time of observation acknowledged the blocked gate, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.2.1; 7.1.10.1; 4.5.3.2 | K 211 | the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.<br><br>1. Corrective Action: BBQ grill that was blocking exit was moved on the afternoon of April 17, 2018.<br>2. ID of Others: All residents are identified to be at risk of not being able to have access to the exit that was obstructed. On 4-18-18 reviewed all exits to ensure none were being obstructed.<br>3. Systemic Change: On 5/8/18 Executive Director provided education to staff on the policy for keeping exits free of obstructions.<br>4. Monitoring: Audits will be conducted weekly X 4 and monthly X2 by ED or designee to ensure all exits are clear of obstructions. All results of audit will be brought to the monthly facility QAPI meeting for review, recommendations, and assess the need for ongoing monitoring. | |
| K 223 SS=E | Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: | K 223 | | 5/10/18 |

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| K 223 | Continued From page 2<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors for hazardous locations in accordance with the requirements could result in injury or death during an emergency. The deficiency affected 2 of 4 smoke compartments. The findings were:<br><br>Observation on 4/17/2018 at 11:02 AM at room 11 revealed a chalk on the self-closing door of the hazardous area. Further observation revealed door chalks at 3 other locations which were all located in hazardous areas. Doors shall be self-closing or automatic-closing, and shall not be secured in the open position at any time.<br><br>Interview with the facility maintenance director at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.2.2.2.7; 7.2.1.8 | K 223 | 1. Corrective Action: Chalks were removed from the 3 doors identified doors.<br>2. ID of Others: There were no chalks in any resident rooms, thus no residents were identified at risk.<br>3. Systemic Change: On 5/8/18 Executive director and maintenance supervisor provided education to all staff that chalks could not be used on self-closing doors.<br>4. Monitoring: Audits will be conducted weekly X 4 and monthly X2 by ED or designee to ensure all closures are not propped open. All results will be brought to the monthly facility QAPI meeting for review, recommendations, and assess the need for ongoing monitoring. | |
| K 341<br>SS=D | Fire Alarm System - Installation<br>CFR(s): NFPA 101 | K 341 | | 5/8/18 |

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| K 341 | Continued From page 3<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to install a fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to install the fire alarm system as required could result in injury or death during an emergency. The deficiency affected 1 of 1 labeling requirements for the power supply to the fire alarm system. The findings were:<br><br>Observation on 4/17/2018 at 11:10 AM in the mechanical room revealed that the electrical panel containing the fire alarm breaker lacked red labeling or a red breaker indicating the fire alarm. Marking the fire alarm breaker with red will expedite locating the correct breaker during an emergency, or prevent power loss to the system. | K 341 | 1. Corrective Action: Red label was put on the electrical panel containing the fire alarm breaker on April 18, 2018.<br>2. ID of Others: All residents were identified to be at risk due to the fire alarm system on the electrical panel not having proper labeling.<br>3. Systemic Change: On 5/8/18 the Executive Director provided education to staff that the panel marked in red on the electrical panel signifies it to be the fire alarm system.<br>4. Monitoring: Audit conducted on May 8th by executive director assured that fire alarm breaker was clearly marked in red. | |

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| K 341 | Continued From page 4<br><br>Interview with the facility maintenance director at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Section: 9.6.1.3<br>2010 NFPA 72, Section: 10.5.5.2.3 | K 341 | | |
| K 345 SS=E | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to provide the listing of all notification devices in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to provide the listing of all notification devices as required may impair adequate testing, and may lead to injury or death due to a fire. The deficiency affected 1 of the 3 major alarm (Initiating, Supervisory, and Notification) testing requirements. The findings were:<br><br>Document review on 4/17/2018 at 1:00 PM | K 345 | 1. Corrective Action: Got into contact with our provider to schedule a smoke damper test, which will be completed by no later than June 15, 2018.<br>2. ID of Others: All residents were identified to be at risk due to damper test not being completed within the timely manner.<br>3. Systemic Change: Damper test to be completed by no later than June 15, 2018.<br>4. Monitoring: Smoke Damper test to now be added as part of our PM fire service inspections. | 6/15/18 |

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| K 345 | Continued From page 5<br>revealed that the facility did not verify appliance locations per approved layout, and the facility did not verify that there were no floor plan changes that affected the approved layout.<br><br>Interview with the facility maintenance director at the time of document review acknowledged the deficiency, and indicated unawareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.3.4.3.1; 9.6; 9.6.1.5<br>2010 NFPA 72, Sections: 14.4.2.2; Table 14.4.2.2.15(c); Example Test and Inspection Report Figure 14.6.2.4 (7.14 and Page 11) | K 345 | 4. Monitoring: Smoke Damper test to now be added as part of our PM fire service inspections. | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler | K 353 | | 5/31/18 |

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| K 353 | Continued From page 6<br>system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to perform sprinkler maintenance and testing in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. Failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected 2 of 2 pressure gauges for the fire sprinkler system. The findings were:<br><br>Observation on 4/17/2018 at 9:48 AM at the sprinkler riser in the closet of the administrator's office revealed that the sprinkler gauges had not been replaced or recalibrated within the last 5 years. One gauge was last tested in 2012, and a date for a second gauge could not be determined.<br><br>Interview with the facility administrator at the time of observation, and at the time of exit, acknowledged the deficiency. He indicated unawareness of the requirement.<br><br>REF: 2012 NFPA 101, Sections: 19.3.5.3; 9.7.5; 9.7.7; 9.7.8<br>2011 NFPA 25, Section: 5.3.2 | K 353 | 1. Corrective Action: New gauges were ordered and will be installed by no later than May 31, 2018.<br>2. ID of Others: All residents were identified to be at risk due to the gauges not being replaced or recalibrated in a timely manner.<br>3. Systemic Change: All gauges to be replaced by 5/31/18.<br>4. Monitoring: Monitoring for gauges needing to be changed will now be part of the PM fire service inspections. | |
| K 753<br>SS=D | Combustible Decorations<br>CFR(s): NFPA 101<br><br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met:<br>o Flame retardant or treated with approved | K 753 | | 5/8/18 |

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| K 753 | Continued From page 7<br>fire-retardant coating that is listed and labeled for product.<br>o Decorations meet NFPA 701.<br>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.<br>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain combustible materials as required could result in fire spread resulting in injury or death during an emergency. The deficiency affected 1 of 4 smoke compartments. The findings were:<br><br>Observation on 04/17/2018 at 10:12 AM outside room 21 revealed that the resident's door was covered by combustible decorations which exceeded more than 30 percent of the surface area of the door.<br><br>Interview with the facility maintenance director at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101 Section: 19.7.5.6 (c) | K 753 | 1. Corrective Action: Resident who occupies room 21 agreed remove most of the pictures that were occupying her door, thus making it in compliance with 30% of surface area standard.<br>2. ID of Others: All residents were identified to be at risk due to the door having combustible decorations thus making it a fire hazard.<br>3. Systemic Change: Executive director provided education on 5/8/18 to all staff on the regulation stating that no more than 30% of the surface of a door with combustible materials.<br>4. Monitoring: Audits will be conducted weekly X 4 and monthly X2 by ED or designee to ensure all doors have 30% or less of combustible materials on them. All results of audit will be brought to the monthly facility QAPI meeting for review, recommendations, and need for ongoing monitoring | |

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| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on April 17, 2018.<br><br>Based upon the findings of the survey team, it was determined the facility was in compliance with all Emergency Preparedness requirements. | E 000 | | |

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

Electronically Signed | 05/13/2018

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.