STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on April 25, 2018. Requirements for Long Term Care 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 of Type II(000) construction with a basement built in 1981. The facility was equipped with a supervised automatic wet sprinkler system and a dry system branch and addressable fire alarm system. The facility had a capacity of 90 certified Medicare and Medicaid beds with a census of 70 residents.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General 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. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and 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 emergency. The	K 211		

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

R. Brian Allen | Administrator | 5/24/18

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.

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K 211	Continued From page 1 deficiencies affected five (5) of nine (9) smoke compartments on the main floor, and the basement floor. The findings were: Observation on 04/25/18 at 10:15 AM revealed in the gated courtyard connecting North B and C wings that the courtyard was part of a required means of egress and that the gates exiting the courtyard were locked with pad locks. Interview with the maintenance director at the time of the observation acknowledged the deficiency, but was unaware of the requirement. The maintenance director acknowledged the courtyard was part of a required means of egress but believed the pad lock was acceptable given that all staff have keys to it. The maintenance director also stated the facility was planning on permanently removing the pad lock once an alarming system for the gate was completed. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.2.2.4 Observation on 04/25/18 at 10:30 AM revealed a ramp located in the boiler room with a rise greater than 6 inches that had no handrails. Observation of the ramp revealed that a handrail had been provided at one point but had been removed. Interview with the maintenance director at the time of observation acknowledged the deficiency, and revealed they were aware of the requiement for ramps requiring handrails, but were unaware	K 211	Ref: K211 Padlock to gate in courtyard connecting North B and C pod has been removed. Staff will be instructed that padlock use on this patio is restricted and to monitor resident safety via gate alarm. Compliance will be monitored by the QAPI team monthly for 3 months and then quarterly. Ref: K211 Maintenance supervisor will contact Plan One Architects to draw up a plan for new handrails on the ramp. The plans will be submitted to OHLS for approval and then go out to bid. Install will be contracted outside the facility.	6-6-18 6-15-18

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K 211	Continued From page 2 of the the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.2.6.1, Section 7.2.5.4.2 Observation on 04/25/18 at 11:45 AM revealed in patient room 303 that storage in the room was limiting the means of egress of the room to less than 48 inches in clear width and blocking the means of egress in some areas. Interview with the maintenance director at the time of observation acknowledged the deficiency, and revealed they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.3.4 Observation on 04/25/18 at 12:47 PM and throughout the survey revealed several exterior doors that are part of the required means of egress which had signs on them stating "PUSH HANDLE DOOR OPENS IN 15 SECONDS". At the time of the survey it could not be determined whether an active delayed egress system was installed and operable on these doors. When tested the doors opened without delay or alarm. Interview with the maintenance director at the time of the observation acknowledged the deficiency, but indicated he was unaware of the requirement. The maintenance director	K 211	Ref: K211 Social worker will visit with resident and family in regards to removing clutter in room so that means of safe egress can be accomplished. Resident will be given the choice of staying in that room and downsizing or moving into a private room. Compliance will be monitored by the QAPI team monthly for 3 months and then quarterly thereafter. Ref:K211 Maintenance staff will test all exit doors for means of delayed egress. All doors with delayed egress will be labeled with the proper signs. Any signs that are on doors without delayed egress will be removed.	6-15-18 6-15-18

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K 211	Continued From page 3 acknowledged the signs and was uncertain whether any delayed egress system was installed on the doors. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.2.2.4(2), Section 7.2.1.6.1	K 211		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to properly test emergency lighting in accordance with the 2012 NFPA 101 Life Safety Code. Failure to test and maintain emergency lighting systems could result in injury or death in the event of an emergency. The deficiency affected the basement floor. The findings were: Review of emergency lighting systems testing documentation on 04/25/18 at 3:00 PM revealed that the facility was not conducting the required monthly 30 second test for its battery operated emergency lighting. Interview with the maintenance director at the time of the survey acknowledged the deficiency and revealed he was unaware of the requirement to test the battery-operated emergency lighting for 30 seconds. He did state they test monthly, but not for the required time.	K 291	Ref: K291 Emergency light test in generator room. Maintenance staff has updated S.O.P for testing the emergency light. Tests are currently being conducted monthly and documented to meet the requirements. Compliance will be monitored by the QAPI team.	5-1-18

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K 291	Continued From page 4 Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.2.9.1, Section 7.9.3	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		

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K 321	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly protect hazardous areas in accordance with 2012 NFPA 101 Life Safety Code. Failure to protect hazardous areas can result in injury or death by allowing the propogation of fire and smoke. The deficiencies affected one (1) of nine (9) smoke compartments, and the basement floor. The findings were: Observation on 04/25/18 at 11:05 AM revealed that the still room was being used to store combustible materials, but the door had no door closer installed. The size of the room was approximately 64 square feet. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and revealed he was aware of the requirement for hazardous areas to have door closers. Interview with the administrator at the time of exit acknowledged the deficiency. Observation on 04/25/18 at 11:20 AM revealed that training director room was being used to store combustible materials, but the door had no door closer installed. The size of the room was over 100 square feet. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and revealed he was aware of the requirement.	K 321	Ref: K321 All combustible items will be removed from still room. This room will no longer be used as storage. An inspection audit will be conducted monthly for 3 months and quarterly there after to ensure items are not being stored in the room. Compliance will be monitored by the QAPI team. Maintenance and commissary staff will be educated on storage requirements. Ref: K321 Maintenance personnel will install door closers on the doors to the training director room. This will ensure compliance if the room is used to store items. An inspection audit will be conducted monthly for 3 months and quarterly there after to ensure that offices and rooms that have storage in them do have door closers. Compliance will be monitored by the QAPI team.	6-15-18 6-15-18

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K 321	Continued From page 6 Interview with the administrator at the time of exit acknowledged the deficiency. Observation at the time of the survey on 04/25/18 at 12:36 PM revealed that the Medical Records office was being used to store combustible materials but the door had no door closer installed. The size of the room was over 100 square feet. Failure to protect hazardous areas can result in injury or death by allowing the propogation of fire and smoke. Interview with maintenance director at the time of the survey acknowledged the deficiency and revealed they were aware of the requirement for hazardous areas to have door closers but unaware of the deficiencies. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.3	K 321	Ref K321 Maintenance will install a door closer on the Medical Records office door. An inspection audit will be conducted monthly for 3 months and quarterly there after to ensure that offices and rooms that have storage in them do have door closers. Compliance will be monitored by the QAPI team.	6-15-18
K 511 SS=E	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 properly maintain clearance to	K 511		

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K 511	Continued From page 7 electrical systems in accordance with 2011 NFPA 70, National Electrical Code. Failure to maintain clearance to electrical equipment could result in injury or death in the event of routine maintenance, or in an emergency. The deficiencies affected the basement floor. The findings were: Observation on 04/25/18 at 10:50 AM revealed that the dryer room had storage in front of four (4) electrical disconnects, which obstructed access and sight. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and revealed he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. Observation on 04/25/18 at 11:05 AM revealed that the still room had storage in front of an electrical disconnect, which obstructed access and sight. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and revealed he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. Reference: 2012 NFPA 101 19.5.1, 9.1.2; 2011 NFPA 70 110.26(A)	K 511	Ref: K511 All storage in the dryer room obstructing access to the electrical disconnects will be removed by maintenance to provide access to the panels. Signs and\or markings will be used to indicate that storage in front of panels is restricted. An inspection audit will be conducted monthly for 3 months and quarterly there after to ensure that access remains unobstructed. Compliance will be monitored by the QAPI team. Ref: K511 Storage will be removed out of still room by maintenance from in front of electrical disconnect to the proper location allowing access to the panels. Signs and\or markings will be used to indicate that storage in front of panels is restricted. An inspection audit will be conducted monthly for 3 months and quarterly there after to ensure that access remains unobstructed. Compliance will be monitored by the QAPI team.	6-15-18 6-15-18
K 920	Electrical Equipment - Power Cords and Extens	K 920		

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K 920 SS=E	Continued From page 8 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly utilize power strips in accordance with 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize extension cords can increase the probability of electrical fire, or develop a tripping hazard. The deficiencies affected eight (8) of nine (9) smoke compartments. The findings were:	K 920		

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K 920	Continued From page 9 Observation on 04/25/18 at 11:55 PM,and throughout the survey,revealed multiple patient rooms with patient medical equipment, including concentraters and CPAP machines, plugged into power strips at patient bed locations. Interview with the maintenance director at the time of the observation acknowledged that power strips were being used in patient bed locations, and revealed he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920	Ref: K920 An inspection will be conducted in all resident rooms by nursing and maintenance staff to ensure no PCREE is plugged into surge protectors of any kind. A monthly inspection will be conducted for 3 months and then quarterly thereafter to ensure compliance. Compliance will be monitored by the QAPI team. All staff will be educated on this requirement.	6-15-18

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/25/2018.	E 000		
E 007	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Documentation review and staff interview revealed that the facility failed to address patient population in the emergency preparedness program. The findings were: Documentation review of the emergency preparedness plan on 04/25/18 at 3:30 PM revealed that the patient population was not addressed in the emergency preparedness program. Interview with the facility administrator acknowledged the deficiency, and revealed they were unaware that this requirement was missing	E 007	Administration will update the Emergency Response Plan with procedures for staff to be able to track and account for resident and staff population during an emergency. The procedure will call for staff to utilize the nursing 24 hour report for a role call of residents and the department schedules for role call of staff. Administration will meet and identify what services the facility has the ability to provide in a n emergency and state them in the Plan. It will be updated to specifically address delegations of authority and any	7/5/18

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

Electronically Signed | 06/06/2018

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E 007	Continued From page 1 from the plan.	E 007	succession plans during an emergency. The QAPI (Quality Assurance Performance Improvement)team and safety team will share in the development of the Plan. A PIP (Performance Improvement Project)will be created by the team in order to establish the procedures, educate staff on the procedures, and monitor monthly that the procedures are effective and being implemented. Documentation of the training will be kept to ensure compliance. The QAPI team will begin the PIP on 6-21-18.	
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including	E 009		7/5/18

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E 009	Continued From page 2 documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Documentation review and staff interview revealed that the facility failed to address collaboration with emergency preparedness officials in the emergency preparedness program. The findings were: Documentation review of the Emergency Preparedness Plan on 04/25/18 at 3:30 PM revealed that a process for cooperating and collaborating with local, tribal,regional, state and federal emergency preparedness was not addressed in the emergency preparedness program. Interview with the maintenance director acknowledged the deficiency, and revealed he was unaware that this requirement was missing from the plan.	E 009	Administration will develop procedures in the emergency preparedness plan specifically addressing the cooperation and collaboration with local, state, tribal, and federal emergency preparedness officials. Currently the facility is a member of the Big Horn County Health Coalition, which coordinates and organizes Emergency Preparedness with each Health Care facility in the area. The WRC QAPI (Quality Assurance Performance Improvement)team and safety team will review the Emergency Preparedness Plan of the Coalition. The team will integrate the Emergency Preparedness Plan of the Coalition with the Emergency Plan of the WRC. A PIP (Performance Improvement Project)will be created by the team in order to establish the procedures, educate staff on the procedures, and monitor monthly that the procedures are effective and being implemented. Documentation of the training will be kept to ensure compliance. The QAPI team will begin the PIP on 6-21-18.	

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	535021	A. BUILDING _____ B. WING _____	04/25/2018

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E 013	Continued From page 3	E 013		
E 013	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013		7/5/18

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E 013	Continued From page 4 this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Documentation review and staff interview revealed that the facility failed implement all required emergency preparedness policies and procedures in the emergency preparedness program. The findings were: Documentation review of the emergency preparedness plan on 04/25/18 at 3:30 PM revealed that several policies and procedures were missing from the emergency preparedness program including subsistence needs, tracking of staff and patients, use of volunteers, and arrangements with other facilities for receiving patients. Interview with the maintenance director acknowledged the deficiency, and revealed he was unaware that this requirement was missing from the plan.	E 013	Administration will develop procedures in the emergency preparedness program in regards to the following: providing subsistence needs, tracking staff and patients, the use of volunteers, and arrangements with other facilities for receiving patients. Currently the facility is a member of the Big Horn County Health Coalition, which coordinates and organizes Emergency Preparedness with each Health Care facility in the area. The WRC QAPI (Quality Assurance Performance Improvement)team and safety team will review the Emergency Preparedness Plan of the Coalition. The team will integrate the Emergency Preparedness Plan of the Coalition with the Emergency Plan of the WRC. Once the WRC Plan is updated, a copy will be provided to the BHCHC. Contact will be made with other facilities to establish and or confirm any Memorandums of Understanding this facility may have with other facilities in regards to receiving patients. Once established, this will be recorded in the WRC Emergency Preparedness Plan. Subsistence needs will be addressed in the Plan to identify what the facility has as	

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E 013	Continued From page 5	E 013	well as quantity. Procedures will be established to provide these needs effectively during an emergency. A PIP (Performance Improvement Project)will be created by the team in order to establish the procedures, educate staff on the procedures, and monitor monthly that the procedures are effective and being implemented. Documentation of the training will be kept to ensure compliance. The QAPI team will begin the PIP on 6-21-18.	
E 029	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Documentation review and staff interview revealed that the facility failed to develop a communication plan in the emergency preparedness program. The findings were: Documentation review of the emergency preparedness plan on 04/25/18 at 3:30 PM revealed that no communication plan had been developed for the emergency preparedness plan. Interview with the maintenance director acknowledged the deficiency, and revealed he	E 029	Administration will develop a communication plan and implement as part of the emergency preparedness plan. Currently the facility is a member of the Big Horn County Health Coalition, which coordinates and organizes Emergency Preparedness with each Health Care facility in the area. The WRC QAPI (Quality Assurance Performance Improvement)team and safety team will review the Emergency Preparedness Plan of the Coalition. The team will integrate the communication aspects of the Emergency Preparedness	7/5/18

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E 029	Continued From page 6 was unaware that this requirement was missing from the plan.	E 029	Plan of the Coalition with the Emergency Plan of the WRC. The QAPI team will also develop internal facility communication procedures. The plan will state communication procedures for staff, residents, and family members in the event of an emergency. Once the WRC Plan is updated, a copy will be provided to the BHCHC. A PIP (Performance Improvement Project)will be created by the team in order to establish the procedures, educate staff on the procedures, and monitor monthly that the procedures are effective and being implemented. Documentation of the training will be kept to ensure compliance. The QAPI team will begin the PIP on 6-21-18.	