RECEIVED
Wyoming Dept of Health
JAN 20 2010
Office of Healthcare

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

PRINTED: 01/04/2010
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
	535051	A. BUILDING 02 - MAIN BUILDING B. WING	12/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 this 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 with a basement of Type V (111) construction built in 1967 and 1972. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds.	K 000	Preparation and execution of this Response and plan of correction does not constitute an 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. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 72473 of the State Operations	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K – 018 Facility Policy same as NFPA 101 Standards Regarding corridor doors. i.e. Facility Policy: Doors protecting corridors In other required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as constructed of 1 ¾ inch solid bond or capable of resisting Fire for a least 20 minutes 1, Environmental Engineer (who) repaired, replaced sited opening with additional fire 2. resistive sheet rock to insure 1 ¾ inch fire resistant door for the O 2 . Then Sealed the sheet rock edges with fire rated caulking and then covered the addition with FRP. (How) 3. Rounds and P.M. will prevent, discover further breaches Of fire resistive security. (Prevention) 4. The NHA, DON and E.E. will conduct Monthly building rounds. The rounds will Include Life Safety Compliance reviews. Completion Date: December 29, 2009	12/29/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — DATE 1/15/2010

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.

R. Dee Cozzens

POC ACCEPTED W/ DEE COZZENS, NHA, ON 1/21/09.

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

PRINTED: 01/04/2010
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
	535051	A. BUILDING 02 - MAIN BUILDING B. WING	12/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443 1/21/09

(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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor doors had a 20 minute rating in 1 of 4 smoke compartments. The findings were: Observation on 12/16/09 at 10:23 AM showed the oxygen storeroom corridor door near resident room #20 was not 1-3/4 inches thick. The door had a 14-inch square section that was only 1-inch thick. At the time of observation the maintenance director reported the door once had a vent that was filled in with a 1-inch thick piece of wood. He further reported that he was aware all corridor doors were required to be 1-3/4 inches thick to meet the 20 minute fire rating.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 2 smoke barrier walls were smoke resistant. The findings were:	K 025	K – 025 12/22/09 Facility Policy same as NFPA 101 Standards regarding smoke barriers dampers etc. i.e Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance Par 8.3 of FLSC. 1. Environmental Engineer (E.E.)(Who) 2. Repaired the west attic smoke barrier wall Penetration with fire rated caulking to seal off the Wall which had been breached by cable placement Personnel from cable tv. (How)) 3. (Prevention) Periodic checks will be made to further ensure smoke Barrier protection, specifically when crawl space Or fire walls are involved with any updates or repairs, 4. (Monitor) The NHA, DON and E.E. will conduct Monthly building rounds. The rounds will include Fire Life Safety Compliance reviews. Completion Date: December 22, 2009	

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

PRINTED: 01/04/2010
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
	535051	A. BUILDING 02 - MAIN BUILDING B. WING _____	12/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 025	Continued From page 2 Observation on 12/16/09 at 11:15 AM showed the west attic smoke barrier wall had one unsealed cable penetration. At the time of observation the maintenance director reported he was aware smoke barrier walls were required to be smoke resistant. He further reported barrier walls were inspected quarterly and after contractors' work in the attic. He was not able to explain why the hole had not been sealed.	K 025	K - 070 Facility Policy same as NFPA 101 Standards Regarding 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. etc. i.e 1. 2. The E.E. removed the portable heaters the day of the survey. 3. Policy has been reviewed and no further portable heating devices will be stored or placed in any rooms. 4. (Monitor) The NHA, DON and E.E. will conduct Monthly building rounds. The rounds will include Fire Life Safety Compliance reviews. Completion Date: December 16., 2009	12/16/09
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 portable space heaters were not being used in resident sleeping rooms in 1 of 4 smoke compartments. The findings were: Observation on 12/16/09 at 10:18 AM showed a space heater was in use in resident room #29. At the time of observation the maintenance director was not aware that space heaters were prohibited in resident rooms. He further reported that he thought enclosed heaters were permitted.	K 070		
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		

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

PRINTED: 01/04/2010
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
	535051	A. BUILDING 02 - MAIN BUILDING B. WING _____	12/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(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 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 receptacles in wet locations were protected in 1 of 4 smoke compartments. The findings were: Observation on 12/16/09 between 9 AM and 10 AM showed electrical receptacles in the B-hall wet room and the receptacle near the ice machine were located within 6 feet of water sources. These receptacles were not protected with GFCI (ground fault circuit interrupter) receptacles. At 9:15 AM the maintenance director reported he was aware receptacles installed within 6 feet of a water source were required to have GFCI protection. Further review of the facility showed all receptacles in resident sleeping rooms located within 6 feet of a water source had GFCI receptacles.	K 147	K 147 Facility Policy same as NFPA 101 Standards regarding electrical receptacles, (outlets) in wet locations unless they are GFCI (ground fault circuit interrupters) 1. E.E. replaced receptacles. 2. GFI outlets were installed at both locations noted by survey team. Pictures of the GFI replacements are available upon request. 3. Wet areas were inspected to insure that GFI are in place at other locations. 4.(Monitor) The NHA, DON and E.E. will con Monthly building rounds. The rounds will include Fire Life Safety Compliance reviews. Completion Date: December 21., 2009 12/21/09	