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 _____	**11/06/2018**

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on November 6, 2018. 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. The facility was a fully sprinklered, single story building with a partial basement of 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 74. .	K 000		
K 211 SS=F	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 document review and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress could result in injury or death in the event	K 211	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center does not admit that the deficiency listed	12/4/18

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

Electronically Signed | 12/05/2018

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.

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K 211	Continued From page 1 of an emergency. The deficiencies affected six (6) of six (6) smoke compartments. The findings were: Document review on 11/06/18 at 1:15 PM revealed that inspection of fire-rated door assemblies had not been conducted in the last 12 months. Fire-rated door assemblies shall be inspected and tested in accordance with the 2010 NFPA 80 annually. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.1, 7.2.1.15.2, 2010 NFPA 80 5.2.1 .	K 211	on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for 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 Door assembly was inspected by qualified person on 12/04/2018. ED educated Maintenance Director on annual Fire Door Assembly Inspection requirement on 11/30/2018. Identification of Others All smoke compartments identified as deficient. Systemic Changes Maintenance Director and Maintenance Assistant received certification on Fire Door Assembly Inspection on 11/30/2018. ED educated Maintenance Director on annual Fire Door Assembly Inspection on 11/30/2018. Monitoring for Compliance ED to present findings of audit and documentation that inspection was completed to next QAPI meeting.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291		12/3/18

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K 291	Continued From page 2 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 document review and staff interview, the facility failed to test and maintain the emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain the emergency lighting could result in injury or death in the event of an emergency. The deficiency affected the exterior emergency generator and transfer switch area. The findings were: Document review on 11/06/18 at 1:15 PM revealed that the emergency battery-operated lighting had not been tested in the last twelve months. Emergency battery-operated lighting must be tested monthly for not less than 30 seconds, and annually for a minimum of 90 minutes. Interview with the maintenance director at the time of the observation revealed he did not believe they had emergency battery-operated lighting, which is why the testing was not being performed. Subsequent observation within the generator and transfer switch area revealed an emergency battery-powered fixture. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1 .	K 291	Corrective Actions 90 minute battery operated light testing completed on 12/03/2018 by Maintenance Director. Battery-operated light passed for both locations. Identification of Others No other external emergency battery-operated lighting. Systemic Changes ED re-educated Maintenance Director on monthly Emergency Battery-Operated Testing requirement on 11/30/2018. Monitoring for Compliance ED to sign off that testing was completed weekly for 12 weeks. Results to be brought to QAPI meeting monthly for 3 months.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		12/14/18

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K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiencies affected six (6) of six (6) smoke compartments and the basement. The findings were: Document review on 11/06/18 at 1:15 PM revealed that the fire alarm annunciator panel had not been tested within the past twelve months. Testing of the fire alarm annunciator panel must be conducted annually. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(1)	K 345	Corrective Actions Fire alarm contractor to do annual testing by 12/14/2018 on annunciator panel and fire alarm notification devices. Identification of Others No other annunciator panels. All fire alarm notification devices identified as untested. Systemic Changes ED educated Maintenance Director on collecting annunciator panel testing documentation annually and fire alarm notification devices testing documentation annually from fire alarm contractor on 12/03/2018 Monitoring for Compliance ED to present findings of audit and documentation that inspection was completed to next QAPI meeting.	

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K 345	Continued From page 4 Documentation review on 11/06/18 at 1:15 PM revealed that the fire alarm notification appliances had not been tested within the past twelve months. Testing of the fire alarm notification appliances must be conducted annually. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(20) .	K 345		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the portable fire extinguishers in accordance with the 2012 101, NFPA Life Safety Code. Failure to test and maintain the portable fire extinguishers could result in injury or death in the event of a fire. The deficiencies affected six (6) of six (6) smoke compartments and the basement. The findings were:	K 355	Corrective Actions Maintenance Director or designee inspected all fire extinguishers on 12/04/2018. Identification of Others All fire extinguishers identified as deficient on documentation. Systemic Changes ED re-educated maintenance department	12/4/18

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K 355	Continued From page 5 Document review on 11/06/18 at 1:15 PM revealed that inspections of the portable fire extinguishers had not been completed for the last twelve months. Inspections of the portable fire extinguishers must be completed at a minimum of 30-day intervals. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.5.12, 9.7.4.1; 2010 NFPA 10 7.2.1.2	K 355	for signing off on inspection on the fire extinguisher tag on 12/04/2018. Monitoring for Compliance ED will audit all fire extinguishers monthly for 3 months. Results of audit to be presented monthly at QAPI for 3 months.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		12/14/18

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K 918	Continued From page 6 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system in accordance with the 2012 NFPA 99, Health Care Facilities Codes. Failure to test and maintain the essential electrical system could result in injury or death in the event of an emergency. The deficiencies affected six (6) of six (6) smoke compartments and the basement. The findings were: Document review on 11/06/18 at 1:15 PM revealed that the facility had conducted an annual operational test of the emergency generator in June of 2018. Documentation revealed that the generator was tested at over 50% of nameplate kW rating for 30 minutes, and at over 75% of nameplate kW rating for 30 minutes. For annual operational tests the generator must operate at over 50% load for at least 30 minutes, and at over	K 918	Corrective Actions Generator contractor to conduct test at 50% load for 30 minutes and 75% load for 60 minutes by 12/14/2018. Identification of Others Facility only has one generator. Systemic Changes ED educated Maintenance Director to conduct generator testing at 50 percent of load for 30 minutes and 75 percent of load for 60 minutes by 12/14/2018. Maintenance Director to test generator 30 minutes at 50% load and 60 minutes at 75% load not less than annually and to document according to company policy and procedure. Any testing failures will be reported and dealt with in accordance with company	

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K 918	Continued From page 7 75% load for 1 hour for a total test duration of not less than 1.5 continuos hours. Documentation revealed that the facility is conducting weekly 30 minute tests of the generator under load from the facility. Interview with the maintenance director at the time of the observation acknowledged the deficiency, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 99 6.4.4.1.1.3; 2010 NFPA 10 8.4.2.3	K 918	policy and procedure. Monitoring for Compliance ED to present results of generator test at next QAPI meeting.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 11/06/2018. .	E 000		
E 020 SS=F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [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. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020		12/10/18

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E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures that address evacuation of the facility. The findings were: Document review of the Emergency Preparedness Plan on 11/06/18 at 1:50 PM revealed that the policy for evacuation of the facility did not include consideration for transportation, nor did it identify location(s) of evacuation. Interview with the facility administrator at the time of exit acknowledged the deficiency. .	E 020	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center 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 for 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 ED entered transportation considerations policy entered into Emergency Disaster Plan on 12/04/2018. ED entered emergency evacuation locations policy into EDP on 12/04/2018. All staff to be educated on evacuation	

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E 020	Continued From page 2	E 020	locations on 12/10/2018. Identification of Others Only one emergency disaster plan. Systemic Changes Emergency Committee to review EDP annually for completion. All changes to EDP to be reviewed in QAPI meeting monthly. Monitoring for Compliance Transportation considerations policy to be reviewed by QAPI at next monthly meeting.	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] 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.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures for family notification. The findings were: Document review of the Emergency	E 035	Corrective Actions Policy written and inserted into Emergency Disaster Plan on 12/02/2018 by ED. Identification of Others Only one Emergency Disaster Plan.	12/2/18

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E 035	Continued From page 3 Preparedness Plan on 11/06/18 at 1:50 PM revealed that no policy was available for addressing a method for sharing information with residents and their families. Interview with the facility administrator at the time of exit acknowledged the deficiency. .	E 035	Systemic Changes Family communication policy entered into Emergency Disaster Plan on 12/02/2018. Emergency Committee to review EDP annually for completion. Changes to EDP to be reviewed in QAPI meeting monthly. Monitoring for Compliance Emergency Response Committee to review EDP annually Changes and updates to be reviewed in QAPI meeting monthly.	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their	E 037		12/10/18

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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E 037	Continued From page 4 expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	11/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 5 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 6 policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to implement policies and procedures for emergency preparedness training and testing. The findings were: Document review of the Emergency Preparedness Plan on 11/06/18 at 1:50 PM revealed an acceptable emergency preparedness	E 037	Corrective Actions ED to train all staff on EDP on 12/10/2018. Identification of Others Only one Emergency Disaster Plan. Systemic Changes ED educated Maintenance Manager that all new hires to be trained on EDP on	

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E 037	Continued From page 7 training and testing program. However, no documentation was available to demonstrate that the training and testing of employees was being conducted. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 037	12/04/2018. ED educated Maintenance Manager that all employees need to be inserviced on EDP annually on 12/04/2018. ED educated SDC to keep record of all inservices on 12/04/2018. Monitoring for Compliance Audit of each new hire to be trained in EDP for next 12 weeks. Results to be reviewed at QAPI meeting for next 3 months.	