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 B. WING	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET 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
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 with plan approval in 1965. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and with a zoned fire alarm system. The facility had a capacity of 62 certified Medicare and Medicaid beds with a census of 49 residents.	K 000	*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 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*	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 5 smoke compartments. The findings were:	K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD All mattresses in room #11 have been removed and placed in a proper storage location on 2/24/2011. The Maintenance Director or designee will make daily rounds and inspect all unoccupied rooms for improper storage of mattresses. Any room not in compliance will be made in compliance immediately and the findings presented to the Executive Director during the Morning Management Meeting and reported at the monthly Performance Improvement Meeting (PI) for further corrective action.	3/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED — (X6) DATE: 3/20/11

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.

POC ACCEPTED W/ TONY JANKSZ, ED, ON 3/30/11.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 16TH STREET RAWLINS, WY 82301

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K 029	Continued From page 1 Observation of resident room #11 on 2/23/11 at 3:10 PM showed seven mattresses were being stored in the room. Per observation the corridor door was not equipped with an self-closing device. At the time of observation the maintenance director reported he was not aware that the storage of numerous mattresses could define an area as a "storage area."	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure delayed egress locks were functional in 1 of 5 smoke compartments. In addition, the facility failed to ensure the exit discharge pathway was accessible and unobstructed in 2 of 5 smoke compartments. The findings were: 1. Observation of the northwest exit door on 2/23/11 at 2:02 PM showed the door was equipped with a delayed egress magnetic lock. It was noted during this observation that the locking mechanism would not release when constant pressure was applied for 30 seconds. The lock did release with the key pad combination. At the time of this observation the maintenance director reported this particular lock needed continual adjustment. 2. Observation of the north exit discharge	K 038	K038 NFPA 101 LIFE SAFETY CODE STANDARD A waiver was requested of the Office of Healthcare Licensing and Survey in order to complete the repaving of the north exit discharge pathway using the following timeline: 1) Estimates from contractors to be obtained by 4/15/2011 2) Plans drawn up and sent to the State Engineer for approval by 6/15/2011. 3) Project completed, weather permitting, no later than 8/01/2011. 4) Final project approval from Office of Healthcare Licensing and Survey obtained by 8/24/2011. The Maintenance Director or designee will check the north exit discharge pathway for ice and snow buildup weekly and after each snowfall and remove the buildup where possible immediately with the results reported to the ED at the Monthly PI meeting for any corrective action. The northwest exit door has had the delayed egress magnetic lock repaired to release when constant pressure was applied for 30 seconds on 3/21/2011.	3/20/11

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K 038	Continued From page 2 pathway on 2/23/11 at 4:45 PM showed the asphalt surface was cracked and missing in some areas, with mud in its place. The pathway was covered with ice in three areas, with the largest patch being 8 by 10 feet wide. The northeast exit discharge ramp was observed to have an ice mound that measured 10 inches high and 28 inches in diameter. At the time of the observation the maintenance director reported the asphalt was damaged by routine use of that surface by the trash collection truck and the food delivery truck. He stated he was not sure why the ice mound had not been noticed and removed.	K 038	The Maintenance Director or designee will check each exit door with a delayed egress magnetic lock weekly for one year for compliance. The results will be reported to the Executive Director at the monthly PI meeting.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit discharge lighting was illuminated in 2 of 5 smoke compartments. The findings were: Observation of the exit discharge lighting on 2/23/11 at 7 PM showed light bulbs were not illuminated above the northeast, north central, and northwest exits. On 2/24/11 at 10 AM the administrator reported he was aware of the lighting requirement. He stated he did not know why the non-functional light bulbs had not been replaced.	K 045	K045 NFPA 101 LIFE SAFETY CODE STANDARD The non-functional light bulbs which are to illuminate the northeast, north central and northwest exits have been replaced on 2/25/2011 by the Maintenance Director. The Maintenance Director or designee will visually check for illumination of the northeast, north central, and north west egresses weekly. Non-functional light bulbs will be replaced immediately and reported to the Executive Director at the Morning Management Meeting and presented at the monthly PI Meeting for further corrective actions.	3/20/11
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=E	Continued From page 3 ~~Required automatic sprinkler systems are~~ continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinkler heads were unobstructed in 1 of 5 smoke compartments. The findings were: Observation of the main dining room on 2/23/11 at 1:21 PM showed two sprinkler heads were obstructed by ceiling mounted lights. The sprinklers were closer than 12 inches from and 3 inches above the bottom of the lights. At the time of observation the maintenance director reported he was aware of the spacing requirement. Furthermore, he reported a contractor had added sprinkler heads last year, but he did not know why these particular heads had not been identified and re-positioned..	K 062	K 062 NFPA 101 LIFE SAFETY CODE STANDARD The two obstructed sprinklers were lowered to meet the NFPA Life Safety Code Standard on 3/9/2011 by a representative from Western States Fire Protection. The Maintenance Director or designee will monitor the facility for any obstructive sprinkler heads during his daily walkthroughs and report his findings to the Executive Director at the monthly PI meeting for corrective action.	3/20/11
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure oxygen storerooms had proper signage in 1 of 5 smoke compartments. The findings were:	K 141		3/20/11

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K 141	Continued From page 4 Observation of the southwest hall oxygen storeroom on 2/23/11 at 2:39 PM showed the corridor door was posted with a sign reading "Oxygen No Smoking." The letters on the sign were only 1/2-inch tall. At the time of observation the maintenance director reported he was not aware the sign was required to have specific minimum language: "Caution, Oxidizing Gas(es) Stored Within, No Smoking." In addition, he stated he was unaware that the sign must be readable from a distance of 5 feet.	K 141	K 141 NFPA LIFE SAFETY CODE STANDARD The southwest hall oxygen storeroom has had a corridor signage meeting K 141 NFPA Life Safety Code Standard posted on 3/15/2011 by the Maintenance Director.	
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure temporary wiring did not replace fixed permanent wiring and failed to provide covers for junctions boxes in 2 of 6 smoke compartments. The findings were: 1. Observation of the kitchen on 2/23/11 at 1:15 PM showed the meat slicer was plugged into a surge protector, which was, itself, plugged into another surge protector. At the time of the observation the kitchen manager reported the area had been cleaned the night before. She stated she did not know why the surge protectors were chained together. 2. Observation in the attic above the clean utility room on 2/23/11 at 3:34 PM showed a square junction box and three conduit pull boxes that did not have covers. At the time of the observation	K 147	The Maintenance Director or designee will monitor all oxygen storeroom corridors for signage compliance. All non-compliant doors will be put in compliance and reported to the Executive Director at the monthly PI meeting. K 147 NFPA 101 LIFE SAFETY CODE STANDARD The second surge protector which was connected to another surge protector with the meat slicer in the kitchen was removed on 2/23/2011. The Dietary Manager or designee will monitor the meat slicer and surge protector	3/20/11

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K 147	Continued From page 6 the maintenance director reported he was aware of the cover requirement, but he had no idea why the missing covers had not been noticed and replaced.	K 147	weekly for compliance for three months and report the results to the Executive Director at the monthly PI for further actions if necessary. The square junction box and three conduit pull boxes in the clean utility room attic had covers put on by the Maintenance Director on 2/28/2011. The Maintenance Director or designee will monitor the facility for any uncovered junction or conduit boxes weekly during his facility rounds. Any uncovered boxes will be covered at the earliest possible time. The results will be reported to the Executive Director at the monthly PI meeting.	