

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

PRINTED: 06/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2019
NAME OF PROVIDER OR SUPPLIER RAWLINS REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on May 22, 2019. 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 basement of Type V (111) construction built in 1965. The building was equipped with a supervised automatic wet sprinkler system, and 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 321 SS=D	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	K 321		6/18/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

Electronically Signed

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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 321	Continued From page 1 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) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiency affected 1 of numerous room in the facility. The findings were: Observation on 05/22/2019 at 11:20 AM in the basement boiler room revealed the self-closing corridor door was being held open by a bucket. Interview with the facility maintenance director at the time of observation acknowledged the bucket, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2	K 321	1. Corrective Action: Bucket that was keeping the door open was removed on the afternoon of May 22, 2019. 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 5-23-19 reviewed all exits to ensure none were being obstructed. 3. Systemic Change: On 6/11/10 Executive Director and maintenance supervisor provided education during the all staff meeting on the policy for not obstructing self-closing corridors. 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. This plan of Correction is the center's		

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K 321	Continued From page 2	K 321	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 the deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a	K 923		6/24/19	

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K 923	Continued From page 3 minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death during an emergency. The deficiency affected 3 of 5 smoke compartments. The findings were: Observation on 05/22/2019 at 10:30 AM in the oxygen storage closet adjacent to room 36 revealed an oxygen bottle sitting unsecured on the floor. Further observation revealed unsecured oxygen bottles in 3 of 6 oxygen storage closets throughout the facility. Interview with the facility maintenance director at the time of observation acknowledged the unsecured bottles, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2.4 2012 NFPA 99, Section: 11.6.2.3(11)	K 923	1. Corrective Action: Facility checked on oxygen tanks on in the facility and ensured all were properly placed and stored on the afternoon of May 22, 2019. 2. ID of Others: All residents were identified to be at risk of harm due to the oxygen tanks not being properly stored. 3. Systemic Change: On 6/11/19 Executive director and maintenance supervisor provided education to all staff about the proper storage for oxygen tanks. 4. Monitoring: Audits will be conducted weekly X 4 and monthly X2 by ED or designee to ensure all oxygen tanks are properly placed in their storage units. All results will be brought to the monthly facility QAPI meeting for review, recommendations, and assess the need for ongoing monitoring 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		

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K 923	Continued From page 4	K 923	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.		

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on May 22, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000			

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