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 _____	**10/22/2019**

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 10/22/2019. Requirements for Long Term Nursing Homes 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 and a zoned fire alarm system. The facility had a capacity of 81 certified Medicare and Medicaid beds with a census of 72 residents. .	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 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.	K 345	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center	11/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/15/2019

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 345	Continued From page 1 Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system. The findings were: Document review on 10/22/19 at 2:15 PM revealed that the facility had not conducted the annual tests of the fire alarm system. Annual tests of the annunciation panels, alarm notification appliances, manual fire alarm boxes, heat detectors, and smoke detectors are required to be conducted. Interview with the maintenance manager at the time of the observation acknowledged 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), Table 14.4.5(20), Table 14.4.5(15)(f), Table 14.4.5(15(e)), Table 14.4.5(15)(h) Document review on 10/22/19 at 2:15 PM revealed that the facility was not activating the fire alarms audible notification devices during the month when fire drills were conducted with the fire alarm in silent mode. The fire alarm system is required to be tested by activation every month. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement.	K 345	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 1. Executive Director and Maintenance Director reviewed documentation on 11/14/2019. Documentation shows that alarm notification devices were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Documentation shows that manual fire alarm boxes were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Documentation shows that heat detectors were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Documentation shows that smoke detectors were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Fire alarm contractor reports that facility has no annunciator panels. 2. Audible fire alarm notification devices were tested on 10/20/2019. Identification of Others 1. Documentation review shows that alarm notification devices were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Documentation shows that manual fire alarm boxes were tested between 01/29/19 – 01/31/19 by contracted fire	

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K 345	Continued From page 2 Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(24) .	K 345	inspector and passed. Documentation shows that heat detectors were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Documentation shows that smoke detectors were tested between 01/29/19 – 01/31/19 by contracted fire inspector and passed. Fire alarm contractor reports that facility has no annunciator panels. 2. Audit completed by Maintenance Director on 11/14/2019 revealed no other months failed to have the audible fire alarm notification devices tested. Systemic Changes 1. Executive Director educated Maintenance Director to review last date of annual fire alarm testing and determination of compliance quarterly on 11/14/2019. 2. Executive Director educated Maintenance Director to conduct monthly testing of audible fire alarm notification devices on 11/14/2019. Monitoring for Compliance 1. Maintenance Director to present last date of fire alarm annual testing and determination of compliance quarterly at QAPI meeting for 12 months. 2. Maintenance Director to present results of audible fire alarm notification devices testing monthly at QAPI meeting for three months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		11/29/19

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K 353	Continued From page 3 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2010 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiencies affected the fire sprinkler system. The findings were: Document review on 10/22/19 at 2:15 PM revealed the facility had conducted the water flow device alarm test in two of the last four quarters. The water flow device alarm test is required to be conducted every quarter. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the	K 353	Corrective Actions 1. Water flow device alarm tested by contracted fire inspector on 10/29/19 and passed inspection. 2. Identified sprinklers over rehabilitation gym and kitchen cleared of obstructions on 11/14/19 by Maintenance Director. Identification of Others 1. Documentation review on 11/14/19 of Contracted Fire Inspector reports shows no deficiencies. 2. Visual inspection of all attic sprinklers on 11/14/19 by Maintenance Director showed one other sprinkler had obstructed movement. Sprinkler head was cleared of obstruction by Maintenance Director on 11/14/19. Systemic Changes 1. Executive Director educated Maintenance Director to review date of most recent water flow device alarm test	

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K 353	Continued From page 4 requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 25 13.2.6.1 Observation on 10/22/19 at 1:55 PM revealed that sprinklers protecting the attic above the rehabilitation room and kitchen had insulation falling on them that would obstruct the sprinkler discharge pattern. Minimum clearances to obstructions must be maintained for all sprinklers. Interview with the maintenance manager at the time of the observation acknowledged 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 25 5.2.1.2 .	K 353	quarterly for compliance on 11/15/2019. 2. Insulation above deficient fire sprinklers secured by facility by 11/29/2019. Monitoring for Compliance 1. Maintenance Director to present last date of water flow device alarm test and determination of compliance quarterly at QAPI meeting for 12 months. 2. Maintenance Director to present evidence of continued securement monthly at QAPI meeting for three months.	
K 355 SS=D	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 observation and staff interview, the facility failed to inspect and test portable fire	K 355	Corrective Actions 1. Fire extinguisher was inspected and	11/15/19

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K 355	Continued From page 5 extinguishers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly inspect and test portable fire extinguishers could result in injury or death in the event of a fire. The deficiency affected one (1) of six (6) smoke compartments. The findings were: Observation on 10/22/19 at 12:40 PM revealed that a portable fire extinguisher located in the corridor adjacent to resident room 26 was last internally examined in February of 2013. Portable fire extinguishers are required to be internally examined every six years. Interview with the maintenance manager at the time of the observation acknowledged 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 7.3.1.2.1	K 355	maintenance 07/26/2019 by fire inspection contractor. Identification of Others 1. Audit completed by contracted fire inspector on 07/26/2019 shows all fire extinguishers were either inspected by the contracted fire inspected and maintenance, or were not yet due for their six year maintenance. Systemic Changes 1. ED educated Maintenance Director of the need for documentation to be readily available at the end of each year on 11/15/2019. Monitoring for Compliance 1. Maintenance director to present audit of required paperwork at monthly QAPI meeting for 3 months and then quarterly thereafter.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		11/29/19

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K 372	Continued From page 6 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke compartment barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoke compartment barriers could result in injury or death in the event of a fire. The deficiency affected two (2) of six (6) smoke compartments. The findings were: Observation on 10/22/19 at 2:10 PM revealed the smoke barrier adjacent to resident room 2 had multiple unprotected penetrations above the corridor ceiling. Smoke barriers shall be continuous through ceiling areas, and all penetrations shall be protected by a system or material capable of restricting the transfer of smoke. Interview with the maintenance manager at the time of the observation acknowledged 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 19.3.7.3, 8.5.2.2, 8.5.6	K 372	Corrective Actions 1. Smoke barrier penetrations repaired by 11/29/2019 by Maintenance personnel. Identification of Others 1. Audit completed on 11/14/19 by Maintenance Director showed two other smoke barriers with unprotected penetrations. All unprotected fire penetrations repaired by Maintenance personnel by 11/29/2019. Systemic Changes 1. Executive Director educated Maintenance Director to review all smoke barriers annually for unprotected smoke barrier penetrations on 11/15/2019. Monitoring for Compliance 1. Maintenance Manager will evidence of work completed during first QAPI meeting after completion of work. 2. Maintenance Manager will present evidence of last annual audit of smoke barrier penetrations quarterly for one year.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 10/22/2019. .	E 000		
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 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:	E 037		11/15/19

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

Electronically Signed | 11/15/2019

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E 037	Continued From page 1 (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. *[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	E 037		

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E 037	Continued From page 2 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 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.	E 037		

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E 037	Continued From page 3 (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: Documentation review and staff interview revealed the facility failed to conduct all requirements of the emergency preparedness training program. The findings were: Document review of the Emergency Preparedness Plan on 10/22/19 at 2:45 PM revealed that no means of demonstrating staff knowledge of the emergency preparedness program were being conducted with staff as part of new employee orientation and annual training. Interview with the facility administrator acknowledged the deficiency, and revealed she was unaware of the requirement. .	E 037	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 1. Staff trained on Emergency Preparedness Plan on 11/14/2019. PRN and seasonal staff will be trained before their next scheduled shift. Staff will	

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E 037	Continued From page 4	E 037	demonstrate knowledge by completing and passing Emergency Disaster Training Post Test. Identification of Others 1. Facility only has one Emergency Preparedness Plan that affects staff. Systemic Changes 1. Emergency Management Committee Members educated on 11/15/19 to complete EDP training with new hires by ED. 2. New hires will demonstrate knowledge by completing and passing Emergency Disaster Training Post Test. Monitoring for Compliance 1. SDC to audit completion of new hires for EDP training and passing Emergency Disaster Training Post Test, and to present findings to QAPI meeting monthly for three months.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based	E 039		11/15/19

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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
E 039	Continued From page 5 exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the	E 039		

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 _____	10/22/2019

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
E 039	Continued From page 6 [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed the facility failed to conduct all required testing of the emergency preparedness program. The findings were: Document review of the Emergency Preparedness Plan on 10/22/19 at 2:45 PM revealed the facility had conducted a full scale test during the previous twelve months, but a second full scale or table top exercise was not conducted within the same time frame. Interview with the facility administrator acknowledged the deficiency, and revealed she was aware of the requirement.	E 039	Corrective Actions 1. Table top exercise completed by IDT on 11/15/2019. Identification of Others 1. Table top exercise under "Corrective Action" fulfills identification of others. Systemic Changes 1. Executive Director educated on 11/15/2019 to conduct table top exercise annually by supervisor. Monitoring for Compliance 1. Emergency Committee to sign off on completion of table top exercise annually upon completion of table top exercise. Results of exercise to be presented at first QAPI meeting held after completion of table top exercise with recommendations for training and supplies necessary to overcome barriers experienced during exercise.	