

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

PRINTED: 07/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 07/03/2018
NAME OF PROVIDER OR SUPPLIER WYOMING RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 890 US HWY 20 SOUTH BASIN, WY 82410		
(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 revisit survey was conducted on 07/03/2018 for all previous deficiencies cited on 04/25/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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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NAME OF PROVIDER OR SUPPLIER WYOMING RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 890 US HWY 20 SOUTH BASIN, WY 82410		
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{E 000}	Initial Comments	{E 000}			
{E 013}	An Emergency Preparedness revisit survey was conducted by Healthcare Licensing and Surveys on 07/06/2018 for previous deficiencies cited on 4/25/2018. Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and	{E 013}			7/19/18

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

TITLE

(X6) DATE

Electronically Signed

07/11/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that any 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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{E 013}	Continued From page 1 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to implement all required emergency preparedness policies and procedures in the emergency preparedness program. The findings were: Documentation review of the Emergency Preparedness Plan on 07/05/18 at 3:00 PM revealed no policy or procedure was available that addressed the use of volunteers in an emergency. Interview with the maintenance personnel acknowledged the deficiency, and revealed they were unaware that this requirement was missing from the plan.	{E 013}	The Maintenance Supervisor will update the Emergency Preparedness Plan with the proper procedures for the use of volunteers in an emergency. The procedure will call for all visitors and volunteers to report to the Chapel which will be a controlled area where the Administrator will be stationed. The administrator will check volunteers in and check for appropriate credentials before volunteers can be utilized. The Maintenance Supervisor will inform the QAPI team and safety team of this deficiency and gather input as well for the procedure. A PIP (Performance Improvement Project) will be created by the team in order to fully establish this procedure and monitor monthly that the procedures are effective and being implemented. The team will also document training that will be conducted by the team's representative who will be appointed to do the training. Documentation of the training will be kept to ensure compliance. The QAPI team		

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{E 013}	Continued From page 2	{E 013}	will begin the PIP on 7-12-18		