STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	**333 N BRIDGER AVE** **PINEDALE, WY 82941**

(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 February 27, 2020. Requirements for Long Tern Care Facilities Section 42 CFR 483.70(a) except as otherwise provided in this 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 of Type V (111) construction built in 1976 and 1983. The building was equipped with a supervised, automatic wet sprinkler system with an anti-freeze loop, and a zoned fire alarm system. The facility had a capacity of 50 Medicare and Medicaid beds with a census of 34 residents. .	K 000		
K 211 SS=D	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 observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress during an emergency	K 211	The facility failed to follow 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress during an emergency resulting in injury or death, as evidenced by	3/6/20

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

Electronically Signed | 03/16/2020

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K 211	Continued From page 1 resulting in injury or death. The deficiency affected one (1) of eight (8) hallways in the facility. The findings were: Observation on 02/27/2020 at 9:05 AM in the hallway adjacent to room 110 revealed medical supplies and a resident lift congesting the corridor. Further observation revealed the clearance in the corridor was reduced to four (4) feet. Interview with the facility maintenance manager at the time of observation acknowledged the congestion, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.1; 7.1.10.1; 4.5.3.2	K 211	congestion in one of the facility hallways. To correct that deficiency, the patient equipment/lift was relocated to a more appropriate area in the hallway. All other hallways were inspected and found no further areas of congestion. Staff were educated on 03/05/2020 regarding the importance of keeping hallways clear in case of fire or need for evacuation of residents. Further, the facility purchased potable medical supply storage that is much smaller in size and can be easily moved. The new purchases were implemented 03/06/2020. To prevent recurrence, maintenance will audit hallways monthly with the fire drill to ensure that halls are free from congestion. Maintenance will report on hallways as a function of QAPI.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		3/6/20

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K 920	Continued From page 2 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Health Care Facilities Code, and the 2011 NFPA 70, National Electric Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiencies affected two (2) of numerous rooms in the facility. The findings were: 1. Observation on 2/27/2020 at 8:58 AM in resident room 106 revealed patient care related electrical equipment (PCREE) plugged into a power strip located next to the resident's bed. Resident rooms with patient care related electrical equipment shall not have a power strip. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2	K 920	The facility failed to follow NFPA 101 Electrical Equipment--Power Cords and Extensions, Tag 0920, as evidenced by a resident's concentrator plugged in a power strip. Also, a resident had an extension cord in the room, supplying power to personal furniture. To correct the deficiencies, the concentrator was unplugged from the power strip and plugged into an appropriate electrical outlet. The extension cord was removed. This occurred on 02/28/2020. Staff were educated on 03/06/2020 on the safe practice of plugging in PCREE appropriately and avoiding use of extension cords. Further, a notice was created for the admissions packet discouraging families from bringing in power strips or extension cords and, instead, alerting maintenance who can provide facility appropriate items. The maintenance supervisor will perform random audits occasionally throughout each month. The maintenance supervisor will also report findings as a function of	

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K 920	Continued From page 3 2012 NFPA 99, Sections: 10.2.4; 10.2.3.6 2011 NFPA 70, Section: 400-8 2. Observation on 2/27/2020 at 9:40 AM in room 13 revealed an extension cord plugged into a power strip creating a daisy chain. Further observation revealed electrical equipment plugged into the power strip. Interview with the facility maintenance manager at time of observation acknowledged the daisy chain, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2011 NFPA 70, Section 400.8	K 920	QAPI.	