STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING **01** B. WING _____	**05/05/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	**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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 05/05/2021. .	E 000		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph	E 036		5/24/21

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

Electronically Signed | 06/04/2021

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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E 036	Continued From page 1 (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed the facility failed to provide a compliant emergency preparedness training and testing program. The findings were:	E 036	1. No residents were identified as being affected. 2. All residents have the potential to be affected if staff are not trained properly per policy on emergency preparedness procedures. No emergency incidents	

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E 036	Continued From page 2 Review of the Emergency Preparedness Plan on 05/05/21 at 2:30 PM revealed that the facility was conducting all required training and testing for the emergency preparedness plan, however, no policy or procedure was provided in the emergency preparedness program for training and testing. It could not be confirmed that the program had been reviewed and updated within the past year. Interview with the facility administrator acknowledged the deficiency, and revealed they were unaware that this requirement was missing from the plan. .	E 036	have occurred in which any residents were affected by lack of staff training on emergency management procedures. 3. The WRC-67 Training and Competency Policy was incorporated in the Emergency Preparedness Program. This policy includes emergency preparedness training for all new hires and for all staff at least annually. The Maintenance Director and/or designee will monitor all new hire orientations to verify the policy for Emergency Preparedness is being followed. All current staff were inserviced on Emergency Preparedness in April 2021 immediately prior to the survey. 4. The Maintenance Director and/or designee will report results of orientation reviews to the QAPI Committee monthly for the next 60 days to monitor compliance. The QAPI Committee will evaluate results to determine if the current plan of correction is effective or if additional audits and/or education is needed and will revise the plan as necessary to ensure compliance.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on May 5th, 2021. Requirements for Long Term Care Facilities Section 42 CFR 483.700(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.	K 000		

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K 000	Continued From page 3 The facility was a fully sprinklered, single story building of Type II (000) construction, with a basement, built in 1981. The facility was equipped with a supervised automatic wet sprinkler system and a dry system branch, and addressable fire alarm system. The facility had a capacity of 90 certified Medicare and Medicaid beds with a census of 69 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 properly maintain means of egress could result in injury or death in the event of an emergency. The deficiency affected one (1) of nine (9) smoke compartments and the basement. The findings were: Observation on 05/05/21 at 11:20 AM revealed that an exterior egress door from the garage, and basement conference room, were installed with electronic locks that did not allow egress through	K 211	1. No residents were identified as being affected. 2. All residents have the potential to be affected by lack of proper egress releases or alarms in an emergency incident. No incidents have occurred with residents and the referenced doors. 3. The Maintenance Supervisor will schedule the security system vendor to install manual push buttons to unlock the garage door and basement conference (training) room and install an audible signal alarm with the initiation of release of the door bar on the exterior egress door by the kitchen. The maintenance	6/25/21

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K 211	Continued From page 4 the doors without the use of a key card. The doors were equipped with a motion sensor and key card reader, but it appeared the push to exit buttons had been removed. Doors in the means of egress are permitted to be equipped with electronical lock hardware that prevents egress, provided that the door is equipped with a motion sensor and manual release device, while also deactivating on power loss and activation of the fire alarm system. Interview with the maintenance staff at the time of the observation acknowledged the deficiency, but indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.2.2.4(3), 7.2.1.6.2 Observation on 05/05/21 at 11:30 AM revealed that the exterior egress door located adjacent to the kitchen was installed with a key card reader and delayed egress hardware. To activate the delayed egress function a crash bar had to be pressed for 3 seconds and then after 15 seconds the electronic lock would deactivate. Upon testing the door it was determined that the audible signal for the delay egress function would only activate when pressing on the crash bar. Once force was applied for 3 seconds the crash bar could be released and there would be no audible signal making it unclear if the delayed egress process was activated. Doors equipped with delayed egress hardware shall activate an audible signal in the vicinity of the door with the initiation of the	K 211	department has been inserviced on the requirements for these doors. Monthly door audits that are conducted in the facility will include the function of the manual release buttons and motion sensor functions in order to ensure proper egress for the referenced doors. The Maintenance Supervisor and/or designee will monitor the completion of the changes to the referenced egress doors and verify correct functioning of the new systems monthly thereafter 4. The Maintenance Supervisor and/or designee will report progress of system repairs and functioning to the QAPI Committee monthly for the next 60 days to monitor compliance. The QAPI Committee will evaluate results to determine if the current plan of correction is effective or if additional repairs, audits and/or education is needed and will revise the plan as necessary to ensure compliance.	

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K 211	Continued From page 5 release process. Interview with the maintenance staff at the time of the observation acknowledged the deficiency, but indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.2.2.4(2), 7.2.1.6.1.1(3)	K 211		