| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535017 | A. BUILDING **01**<br>B. WING _____ | **11/17/2021** |

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

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| E 000 | Initial Comments<br><br>An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 11/17/2021.<br>. | E 000 | | |
| E 026 SS=F | Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)<br><br>§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).<br><br>[(b) Policies and procedures. The [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. | E 026 | | 12/1/21 |

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

Electronically Signed | 12/13/2021

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| E 026 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to demonstrate their role under a waiver declared by the secretary in accordance with Section 1135 of the Act.<br><br>Document review of the Emergency Preparedness Plan on 11/17/2021 starting at 2:20 PM revealed that the plan did not include a policy to identify the role of the facility and other providers to receive patients in the event that the facility's operation are limited, or operations are halted.<br><br>Interview with the facility administrator at the time of the observation acknowledged the deficiency, and indicated she was unaware that this requirement was missing.<br><br>Interview with the facility maintenance staff, who were delegated in the absence of the administrator, at the time of exit acknowledged the deficiency.<br>. | E 026 | E000: The facility failed to demonstrate their role under a waiver declared by the secretary in accordance with Section 1135 of the Act.<br>a) Observation noted that Emergency Preparedness Plan did not include a policy to identify the role of the facility and other providers to receive patients in the event that the facility□s operations are limited or operations are halted.<br>To correct the initial non-compliance, the facility has developed the policy and placed in the Emergency Preparedness Plan. The facility obtained appropriate contact numbers and included those as well.<br>To ensure further compliance, checklist was obtained that contained all emergency preparedness requirements and the remainder of the plan will be double checked utilizing the appropriate parameters.<br>To prevent further deficiencies, the administrator will audit plan and present for QAPI. | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on November 17, 2021.<br><br>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 | K 000 | | |

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| K 000 | Continued From page 2<br>National Fire Protection Association.<br><br>The facility was a fully sprinklered, single story building of Type V (111) construction with plan approval in 1976 and 1983. The building was equipped with an automatic wet sprinkler system with an anti-freeze loop, and a zoned fire alarm system. The facility had a capacity of 50 certified Medicare and Medicaid beds with a census of 31 residents.<br>. | K 000 | | |
| K 293 SS=E | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain exit signs as required could delay egress during an emergency, and result in injury or death. The deficiency affected one (1) of numerous exit signs throughout the facility. The findings were:<br><br>Observation on 11/17/2021 at 3:11 PM in the north corridor at the cross-corridor doors near the intersection to the dining room, looking towards the nurses station, revealed that a directional | K 293 | K293: The facility failed to maintain exit signs as required.<br>a) Observation noted that in the north corridor at the cross-corridor doors near the intersection to the dining room, a directional mirror had been installed at the ceiling, and was located directly in front of the exit sign.<br>To correct the initial non-compliance, the facility removed the directional mirror, thereby, allowing unhindered visualization of the exit sign.<br>To ensure further compliance, other exit | 12/1/21 |

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| K 293 | Continued From page 3<br>mirror had been installed at the ceiling, and was located directly in front of the exit sign. This installation blocked visibility to the exit sign from the means of egress when viewing from the wing towards the central nurses station.<br><br>Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement to maintain visibility of the exit sign.<br><br>Interview with the facility maintenance staff, who were delegated in the absence of the administrator, at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.2.1; 7.10.1.2.1<br>. | K 293 | signs were double checked to ensure no obstructions.<br>Staff were educated during all staff meeting<br>To prevent future non-compliance, maintenance staff will review signage and report as a function of QAPI.<br>(12/01/2021) | |
| K 363<br>SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided | K 363 | | 12/16/21 |

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| K 363 | Continued From page 4<br>with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to to ensure that doors opening to the corridor are provided with a means of keeping the doors shut in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure that corridor doors can be kept in the closed position could contribute to the spread of smoke and fire during an emergency, and result in injury or death. The deficiencies affected three (3) of numerous doors throughout the facility. The findings were:<br><br>(1) Observation on 11/17/2021 at 2:44 PM of the doors at the north end of the grand dining room revealed that the western leaf of the door would not latch when released from the open position. | K 363 | K363: The facility failed to ensure that doors opening to the corridor are provided with a means of keeping the doors shut in accordance with 2012 NFPA 101, Life Safety Code.<br>a) Observation noted that the door at the north end of the grand dining room would not latch when released from the open position.<br>To correct the issue, latch was inspected and lever for the latch was placed in the correct position.<br>b) Observation noted that the eastern door of the Howard Smith dining room revealed that the doors opened to the corridor and were not provided with a means of keeping those doors in a closed | |

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| K 363 | Continued From page 5<br>(2) Observation on 11/17/2021 at 2:57 PM at the eastern door of the Howard Smith dining room revealed that the doors opened to the corridor, and were not provided with a means of keeping the doors in the closed position.<br><br>(3) Observation on 11/17/2021 at 3:13 PM in the sun room revealed that the door opened to the TV room, and that the TV room was open to the corridor. Further observation revealed that the door separating the sun room and TV room had once been provided with a latching mechanism to keep the door in the closed position, but that it had been removed.<br><br>Interview with the facility maintenance manager at the time of each observation acknowledged the deficiencies, and indicated he was not aware of the requirement.<br><br>Interview with the facility maintenance staff, who were delegated in the absence of the administrator, at the time of exit acknowledged each deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.3.6.3.5<br>. | K 363 | position.<br>To correct this non-compliance, the facility ordered striker plates and doorknobs for the handles. Once received, the maintenance team will install.<br>c) Observation revealed that the Sunroom door opened to the TV room and that the TV room was open to the corridor. Further, the door did not have a latching mechanism to keep the door in a closed position.<br>To correct that issue, new hardware (striker plate and doorknob) has been ordered. Once received, facility maintenance will install. (12/16/2021)<br>To promote further compliance, the maintenance team audited all doors to ensure proper latching and opening.<br>To prevent further non-compliance, maintenance will conduct regular audits of doors and report as a function of QAPI. | |
| K 753<br>SS=D | Combustible Decorations<br>CFR(s): NFPA 101<br><br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met:<br>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.<br>o Decorations meet NFPA 701.<br>o Decorations exhibit heat release less than | K 753 | | 12/16/21 |

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| K 753 | Continued From page 6<br>100 kilowatts in accordance with NFPA 289.<br>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain interior decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain interior decorations as required can contribute to the spread of fire in an emergency, and result in injury or death. The deficiencies affected two (2) of numerous rooms throughout the facility. The findings were:<br><br>(1) Observation on 11/17/2021 at 3:03 PM in resident room 2 revealed an artificial Christmas tree located within the resident's room. Interview with the facility maintenance staff at the time of the observation could not establish that the artificial tree had been verified to be flame resistant, or that the tree had been treated with an approved fire-retardant coating.<br><br>(2) Observation on 11/17/2021 at 3:16 PM in the medical records office revealed that photographs of facility residents had been hung from the walls of the office, and covered approximately 50 percent of the aggregate wall area within the room. Additional observation revealed that a majority of the photographs were printed on standard paper, and were not enclosed within frames. | K 753 | K753: The facility failed to maintain interior decorations in accordance with the 2012 NFPA 101, Life Safety Code.<br>a) Observation noted an artificial Christmas tree located in resident room 2. Facility lacked evidence that the artificial tree had been verified to be flame resistant, or that the tree had been treated with an approved fire-retardant coating.<br>To correct the deficiency, the Christmas tree was treated with approved fire-retardant coating and tagged to provide evidence of such.<br>b) Observation of the medical records office noted that photographs, on standard printer paper, were hung from the walls of that office and covered approximately 50% of the room.<br>To correct the deficiency, resident photos were removed from the walls and disposed of.<br>To promote facility compliance, all new decorations, including holiday decorations, were inspected for evidence of compliance with 2021 NFPA guidelines.<br>Families were educated via letter 12/03/2021<br>Staff were educated on requirements of | |

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| K 753 | Continued From page 7<br>Interview with the facility maintenance staff at the time of each observation acknowledged the deficiency, and indicated they were aware of the requirement.<br><br>Interview with the facility maintenance staff, who were delegated in the absence of the administrator, at the time of exit acknowledged each deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.7.5.6 (1); 19.7.5.6 (4)(c) | K 753 | decorations and wall coverings at staff meeting 12/16/2021.<br>To prevent future non-compliance, maintenance will audit decorations periodically and report as a function of QAPI. (12/16/2021) | |