STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**03/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	**1210 CANYON HILLS RD** **THERMOPOLIS, WY 82443**

(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 03/30/22. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/30/2022. 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 National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (000) construction with a basement built in 1954 and additions of the same construction type built in 1985 and 1990. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 39 residents.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		5/14/22

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

Electronically Signed | 04/22/2022

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K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observation and staff interview, the facility failed to properly maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain egress doors could result in injury or death in the event of an emergency that required evacuation. The deficiencies affected doors in two (2) of three (3) smoke compartments. The findings were: 1) Observation on 03/30/2022 at 11:29 AM revealed an egress door on the southwest side of the building with delayed egress hardware. Observation of the door revealed a sign that read "EMERGENCY EXIT ONLY PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". Upon testing the door it was determined that the delay on the releasing of the door was 30 seconds and not 15 seconds as posted. A delayed egress door may be set to 30 seconds for the lock release, but the sign shall accurately state that time delay. Interview with the maintenance manager at the	K 222	1. The facility will properly maintain egress doors in accordance with the 2012 NFPA 101. A sign was posted on the egress door on the southwest side of the building stating “EMERGENCY EXIT ONLY PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 30 SECONDS.” The delayed egress hardware on the west side egress door was repaired. The barrel bolt on the “Cut and Curl” room door was removed. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. Executive Director/Maintenance Director will educate staff on the NFPA requirement that all egress leading in and out of the facility are to be equipped with hardware that allows the egress to open after pressure is applied to the crash bar for the indicated time posted on the door. Also that barrel bolts are prohibited on all	

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K 222	Continued From page 3 time of the observation acknowledged the deficiency, and indicated that they were unaware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.2.2.4, 7.2.1.6.1.1 2) Observation on 03/30/2022 at 11:45 AM revealed an egress door on the west side of the building with delayed egress hardware. It was attempted to activate the delayed egress system by pushing on the crash bar of the door. After several attempts it was determined that the delayed egress hardware was not working properly, and would not release the doors. The magnetic locks associated with the delayed egress system were still able to be deactivated by using the adjacent keypad. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were unaware that the delayed egress door was not working properly. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.2.2.4, 7.2.1.6.1.1 3) Observation on 03/30/2022 at 12:27 PM at the "Cut and Curl" room revealed a barrel bolt latch located on the ingress side of the door. In the event that the barrel bolt was latched while someone was inside the room there would be no way for that person to unlatch it. Doors within the required means of egress shall not be equipped	K 222	means of egress unless meeting an approved exception. 4. Facility will monitor daily. Findings are to be reported at daily “stand up” meeting and recorded in Maintenance Log.	

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K 222	Continued From page 4 with a latch or lock that requires that use of a tool or key from the egress side unless meeting an approved exception. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.2.2.4	K 222		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: . Based on observation and staff interview, the facility failed to properly maintain means of egress width in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain means of egress width could result in injury or death in the event of an emergency. The deficiency affected one (1) of three (3) smoke compartments. The findings were:	K 232	1. The facility will properly maintain means of egress width in accordance with the 2012 NFPA 101, Life Safety Code. Equipment including stationary bike and stair steps were relocated so as not to impede means of egress width. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern	5/14/22

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K 232	Continued From page 5 Observation on 03/30/2022 at 11:41 AM revealed Physical Therapy (PT) equipment being used and stored in the corridor directly outside of the PT room. This equipment included a stationary bike and stair steps. The equipment was located on one side of the corridor, which was 8' in width, and was not securely attached to the floor or wall. The equipment reduced the clear width of the corridor to approximately 5'. Where corridors are 8' in width fixed furniture that is securely attached to the floor or wall and do not reduce the clear unobstructed corridor width to less than 6' may be permitted. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were unaware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.3.4(5)	K 232	will be added to maintenance schedule log as appropriate. 3. ED/designee educated staff on the requirement of properly maintaining means of egress width in accordance with the 2012 NFPA 101, Life Safety Code. 4. Facility will monitor daily. Findings are to be reported at daily “stand up” meeting and recorded in Maintenance Log.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		5/14/22

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K 324	Continued From page 6 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: . Based on observation and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect cooking facilities could result in injury or death in the event of a fire. The deficiency affected one (1) of one (1) kitchen. The findings were: Observation on 03/30/22 at 12:38 PM revealed a gas cook-top under a commercial exhaust hood located in the facility's kitchen. Observation of the cook-top revealed that no means was provided to ensure it is returned to the approved location after being moved. Cooking appliances requiring fire-extinguishing protection shall be provided with a means of returning to the approved location after being moved for cleaning or maintenance purposes. Interview with the maintenance manager at the	K 324	1. The facility will ensure that appliances requiring fire-extinguishing protection shall be provided with a means of returning to the approved location after being moved for cleaning or maintenance purposes. The castor wheels were removed from the oven and replaced with permanent legs so as to ensure it remains in the required location. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. ED/designee educated dietary and maintenance staff on the requirement that appliances requiring fire-extinguishing protection shall be provided with a means of returning to the approved location after being moved for cleaning or maintenance	

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K 324	Continued From page 7 time of the observation acknowledged the deficiency, and indicated that they were unaware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.3.2.5.5, 9.2.3; 2011 NFPA 96 12.1.2.3	K 324	purposes. 4. Facility will monitor weekly x 4 weeks and monthly x 2 months (90 days). Findings to monthly QAPI and recorded in Maintenance Log. K353	
K 353 SS=E	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 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 document review and staff interview, the facility failed to properly test and maintain the fire sprinkler system in accordance with the 2011 NFPA 25, Standard for the Inspection, Testing,	K 353	1. In accordance with NFPA regulation the facility will ensure that an internal pipe inspection of the fire protection system will be completed every 5 years. The facility scheduled in internal pipe inspection with	5/14/22

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K 353	Continued From page 8 and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of one (1) fire sprinkler system. The findings were: Document review on 03/30/2022 starting at at 1:15 PM revealed that the fire sprinkler system had been tested in December of 2021 for all annual and quarterly required tests. Review of the documentation revealed that an internal piping inspection had not been completed in the last 5 years, and that it was recommended by the contractor that the inspection be scheduled. Interview with the maintenance manager at the time of the observation revealed that he was unaware of the required internal piping inspection needing to be done every 5 years and that he was unaware of the deficiency. He stated that he did not believe the inspection had been completed as of that time. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2011 NFPA 25 14.2.1	K 353	approved contractor on 4/19/22. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. ED/designee will educate maintenance staff on the requirement that an internal pipe inspection must be conducted on the fire sprinkler system every 5 years. 4. Facility will monitor for compliance weekly x 4 weeks and monthly x 2 months (90 days) and annually after every annual fire protection system inspection. Results to monthly QAPI and recorded in Maintenance Log.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective	K 374		5/14/22

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K 374	Continued From page 9 plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: . Based on observation and staff interview, the facility failed to properly maintain smoke compartment doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain smoke compartment doors could result in injury or death in the event of a fire. The deficiencies affected one (1) of two (2) sets of smoke compartment doors. The findings were: Observation on 03/30/2022 at 12:15 PM revealed a set of cross corridor doors that were part of a smoke barrier for separation of smoke compartments. The cross-corridor doors are normally held open with magnetic hold open devices. When released, the doors did not completely shut, and a noticeable gap between the doors was observed. When closed, doors in smoke barriers shall leave only the minimum clearance necessary for proper operation. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement.	K 374	1. The facility will properly maintain smoke compartment doors in accordance with the 2012 NFPA 101, Life Safety Code. Paint and debris was removed from the edges of the smoke doors in order for them to shut properly. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. ED/designee will educate maintenance staff on the requirement that smoke compartment doors are to be properly maintained to ensure that they function properly in the event of an emergency. 4. Facility will monitor daily. Findings are to be reported at daily “stand up” meeting and recorded in Maintenance Log.	

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K 374	Continued From page 10 Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.3.7.8, 8.5.4.1	K 374		
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on document review and staff interview, the facility failed to properly inspect and maintain fire-rated door assemblies in accordance with the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and maintain the fire-rated door assemblies could result in injury or death in the event of an emergency. The deficiency affected all fire-rated doors in the facility. The findings were: Document review on 03/30/2022 starting at at	K 761	1. The facility will ensure that Fire-rated door assemblies shall be inspected annually by an individual with knowledge, training, or experience of the inspection requirements. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. ED/designee will educate maintenance staff on the requirement that	5/14/22

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K 761	Continued From page 11 1:15 PM revealed that the annual inspection of fire-rated door assemblies had not been conducted within the past 12 months. Fire-rated door assemblies shall be inspected annually by an individual with knowledge, training, or experience of the inspection requirements. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 80 5.2.1	K 761	Fire-rated door assemblies shall be inspected annually by an individual with knowledge, training, or experience of the inspection requirements. 4. Facility will monitor for compliance weekly x 4 weeks and monthly x 2 months (90 days) and annually after every annual fire protection system inspection. Results to monthly QAPI and recorded in Maintenance Log.	
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 (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	K 920		5/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**03/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	**1210 CANYON HILLS RD** **THERMOPOLIS, WY 82443**

(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 920	Continued From page 12 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 utilize power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize power strips could result in injury or death in the event of electrical or equipment failure. The deficiency affected three (3) of thirty six (36) resident rooms. The findings were: Observation on 03/30/2022 at 11:55 AM and throughout the survey revealed power strips located in the patient care area while Patient Care Related Electrical Equipment (PCREE) was present. Observation of resident rooms 9, 31, and 19 revealed oxygen concentrators that were either plugged directly into a power strip, or were located near a power strip. PCREE shall not be plugged into power strips, and power strips shall not be located in the patient care area when PCREE is present. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency.	K 920	1. The facility will ensure that power strips in the patient care vicinity may not be used for non-patient care related electronic equipment where PCREE use is required. PCREE shall not be plugged into power strips, and power strips shall not be located in the patient care area when PCREE is present. 2. Audit completed by Executive Director/Maintenance Director on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. ED/designee will educate maintenance staff on the requirement that PCREE shall not be plugged into power strips, and power strips shall not be located in the patient care area when PCREE is present. 4. Facility will monitor daily. Findings are to be reported at daily “stand up” meeting and recorded in Maintenance Log.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 13 Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920		