STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING **01** B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET** **RAWLINS, WY 82301**

(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 03/23/2022. .	E 000		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact	E 031		5/11/22

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

Electronically Signed | 04/18/2022

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 031	Continued From page 1 information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain the emergency preparedness contact information accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in a lack of necessary communication with State agencies in the event of an emergency. The deficiency affected the contact list in the emergency preparedness plan. The findings were: Document review of the emergency preparedness plan on 03/23/22 starting at 1:00 PM revealed that the contact information section did not include contact information for the State ombudsman's office as required. Interview with the facility maintenance manager at the time of the observation acknowledged the lack of contact information for the State ombudsman's office. Interview with the facility administrator at the time of exit acknowledged the deficiency. .	E 031	This plan of Correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. Corrective action- Contact information for the State ombudsman□s office was added to the emergency preparedness book located at the front nurse□s station on 3/25/22 Identification of others- One other book, located at the back-nurse□s station, was found to also not have State ombudsman□s office contact information. Maintenance director updated this book on 3/25/22 Systemic change- Executive director and Maintenance director reviewed education on the regulation to help ensure future compliance on 4/15/22 Monitoring- Monthly checks will be	

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E 031	Continued From page 2	E 031	completed by Maintenance director/ designee on the Emergency preparedness x three months to ensure completion of plan and that updates are completed in a timely manner. Results will be taken to QAPI to determine compliance and frequency of ongoing monitoring-	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 03/23/2022. 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 with basement of Type V (111) construction built in 1965. The building was equipped with a supervised automatic wet sprinkler system, with an anti-freeze branch, and an addressable fire alarm system. The facility had a capacity of 62 certified Medicare and Medicaid beds with a census of 40 residents. .	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	K 200		5/11/22

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K 200	Continued From page 3 citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain door leaf encroachment within the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain door leaf encroachment as required could result in the delay of occupant egress during an emergency, which could result in injury or death. The deficiency affected all doors to storage closets opening to the corridor throughout the facility. Observation on 03/23/22 starting at 10:40 AM, and throughout the survey, revealed that doors used to access these storage closets would not swing to the full-open position, and could impede the required width of the means of egress. Observations included the nursing supply closet by the mds room, which impacted the corridor handrail, and opened to within approximately 18 inches from the wall in the full-open position. Additional observation included the O2 storage closet adjacent to exit 2, which included a self-closing device that limited the door swing to ninety (90) egress when in the full-open position. These observations were made at all storage and O2 storage closets throughout the facility. Interview with the facility maintenance manager at the time of each observation acknowledged the condition of each door, and indicated that he was not aware of the requirement to maintain a	K 200	This plan of Correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. Corrective action- All storage and 02 storage closets in center,that had hand rails directly behind doors had hand rails removed to allow for doors to swing to fully open position. Doors with self-closing devices, that limited door swing will have devices removed by 5/11/22. Identification of others- All storage and 02 storage closet doors were identified during survey process Systemic change- Executive director and Maintenance director reviewed the means of egress requirements to help ensure future compliance on 4/15/22 Monitoring- Closet doors will be audited twice a month by Maintenance	

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K 200	Continued From page 4 maximum project of seven (7) inches into the required width of the corridor. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.1, 7.2.1.4.3.1 .	K 200	director/designee for 3 months to ensure doors are able to come to a fully open position and not project more than 7 inches into the corridor. Results of audits will be taken to QAPI to determine compliance need for ongoing monitoring.	
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 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	K 222		5/11/22

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K 222	Continued From page 5 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 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: 1. Based on observation and staff interview, the facility failed to maintain exit doors with delayed-egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress in the event of an emergency resulting in injury or	K 222	Corrective Action: Exit doors with delayed egress will have undergone maintenance to ensure hardware is in good repair and are operating appropriately by 5/11/22. Appropriate signage was placed on delayed egress	

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K 222	Continued From page 6 death. The deficiency affected three (3) of five (5) exterior egress doors throughout the facility. The findings were: Observation on 03/23/22 starting at 10:47 AM at exit door 2 revealed that the door's panic hardware was loosely assembled, and required excessive force to initiate an irreversible process to release the lock. It was observed that when the panic bar was pushed near the hinge side of the door, the excessive play in the assembly did not activate the delayed-egress systems. As such, occupants would be required to apply force at the latch side of the door to initiate the irreversible delayed-egress system. This condition was also observed at exit doors 4 and 7. Interview with the facility maintenance manager at the time of each observation acknowledged the loosely assembled panic bars, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. 2. Based on observation and staff interview, the facility failed to maintain exit doors with delayed-egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress in the event of an emergency resulting in injury or death. The deficiency affected one (1) of five (5) exterior egress doors throughout the facility. The findings were: Observation on 03/23/22 at 11:24 AM at the south patio exit revealed that the door was provided	K 222	door at South Solarium on 4/8/22 ID of others: All exit doors with delayed egress were audited to ensure appropriate signage and that hardware assembled to require appropriate force to initiate doors panic hardware on 4/15/22 Systemic change- Executive director and Maintenance director or designee reviewed education on the regulation to help ensure future compliance on 4/15/22 Monitoring: Maintenance director/ designee will audit all delayed egress doors 2 x per week monitoring x 1 month and weekly x 1 month for 3 months. Results of audits will be taken to QAPI to determine compliance need for ongoing monitoring.	

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K 222	Continued From page 7 with a wanderguard and delayed-egress system. Further observation revealed that the door was not provided with a readily visible, durable sign indicating PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS. Interview with the facility maintenance manager at the time of the observation acknowledged the lack of the required signage, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.4, 7.2.1.6.1.1(3) and 7.2.1.6.1.1(4) .	K 222		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		5/11/22

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K 321	Continued From page 8 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain protection for storage areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain storage areas as required could lead to smoke or fire spread during an emergency, resulting in injury or death. The deficiency affected two (2) of numerous rooms within the facility. The findings were: Observation on 03/23/22 at 11:31 AM at resident rooms 44 and 48 revealed that the rooms were being utilized for storage. Further observation revealed that the spaces were sprinklered, but that the doors were not provided with self- or automatic-closing devices. Interview with the facility maintenance manager and facility administrator at the time of each observation acknowledged the use of resident rooms for storage, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 321	Corrective action- All storage items being stored in room 48 were moved to room 44. Room 44 had self-closing device installed on door on 4/11/15 Identification of others- All storage rooms were audited to ensure self-closing devices were in place with none others identified on 4/15/22 Systemic changes- Executive director and Maintenance will review education on the regulation to help ensure future compliance by 5/11/22 Monitoring- Storage room doors will be audited by maintenance director/ designee twice a month for 3 months to ensure self-closing devices are in place as appropriate for rooms with combustibles requiring self-closing doors. Results of audits will be taken to QAPI to determine compliance need for ongoing monitoring.	

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K 321	Continued From page 9 REF: 2012 NFPA 101, Sections 19.3.2.1.2, 8.4.3.5 .	K 321		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system as required could lead to system malfunction or failure during an emergency and result in injury or death. Document review on 03/23/22 starting at 1:00 PM revealed that the facility had performed the semi-annual sealed lead acid battery inspection and battery load voltage test on 03/08/22. No documentation was available to demonstrate that a second semi-annual test had been performed during the previous twelve (12) months. Interview with the facility maintenance manager at the time of the observation acknowledged that no	K 345	Corrective action- A sealed lead acid battery inspection and battery inspection and battery load voltage test was completed on 4/11/22 Identification of others- N/A (one fire alarm system in center) Systemic changes- Executive director and Maintenance director will review the fire system inspection requirements to help ensure future compliance by 5/11/22 Monitoring- Maintenance director/ designee will take fire safety inspection schedule to QAPI. Schedule will be reviewed every month for 3 months to ensure appropriate scheduling is in place for required tests. QAPI to determine compliance, recommendations and need	5/11/22

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K 345	Continued From page 10 additional documentation was available, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.4.1, 9.6.1.3 2010 NFPA 70, Table 14.3.1(3)(d) .	K 345	for ongoing frequency of monitoring.	
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 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 ensure that opening protectives at smoke barriers for the subdivision of building spaces are maintained in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain opening protectives as required could result in smoke spread throughout the facility and result in injury or death. The deficiency affected all cross-corridor doors at smoke compartment	K 374	Corrective action- Fire door bristles were ordered on 4/11/15 to be installed upon receipt to all cross- corridor doors to ensure doors will fully close by 5/11/22 Identification of others- N/A- All cross-corridor doors identified as having the potential to not close correctly 4/11/22	5/11/22

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RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET** **RAWLINS, WY 82301**

(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 374	Continued From page 11 walls throughout the facility. Observation on 03/23/22 starting at 11:10 AM at the cross-corridor doors located in the east smoke barrier wall revealed that the doors were provided with a wooden astrigal on one leaf. It was observed that the doors must be closed in the proper sequence allowing the astrigal leaf to close last. When this leaf was allowed to close first, the non-astrigal leaf would impact the astrigal, which would prevent both leafs from stopping in a fully-closed position when release from the automatic-closing device as no coordinator was provided. This condition was observed at all cross-corridor doors at smoke compartments throughout the facility. Interview with the facility maintenance manager at the time of each observation acknowledged the atrigals interfering with the doors ability to close, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 19.3.7.8(1)	K 374	Systemic Change-Executive director and Maintenance reviewed smoke compartment requirements to help ensure future compliance on 4/15/22 Monitoring- Upon completion of installation the cross-corridor doors will be tested by Maintenance director/designee twice a week for x 1 month and once a week x 2 months to ensure complete closure. Results of these audits will be taken to QAPI to determine compliance and need for ongoing frequency of monitoring.	