STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING **01** B. WING _____	**12/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE** **RIVERTON, WY 82501**

(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 12/08/2022. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an	E 004		1/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/04/2023

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 004	Continued From page 1 all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to update the emergency preparedness plan (EPP) as required in accordance with §483.73(a). Failure to update the EPP could result in incorrect information and procedures being utilized in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 2:15 PM revealed that the facility's emergency preparedness plan had not been reviewed and updated in the past 12 months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	E 004	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. Corrective Actions 1) AIT, and Maintenance Director were educated by E.D. to understand the importance of maintaining the Emergency Preparedness Plan and having the outside entities involved. 2) An AdHoc QAPI meeting was held on	

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E 004	Continued From page 2	E 004	12/29/2022 to discuss this POC and its adaptation. Identification of Others The Emergency Preparedness was updated on 12/29/2022, an EPD/EPF meeting was conducted with a plan in place. Monitoring for Compliance The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness Plan one time per month X 12 months at QAPI. 01/15/23	
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a	E 009		1/15/23

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E 009	Continued From page 3 disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials in accordance with §483.73(a)(4). Failure to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials could result in an inadequate response from emergency officials in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 2:15 PM revealed that the facility's emergency preparedness plan did not include a process for cooperation and collaboration with emergency preparedness officials. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the	E 009	E009 Corrective Actions 1) AIT, and Maintenance Director were educated by E.D. to understan1 the importance of maintaining the Emergency Preparedness Plan and having the outside entities involved. 2) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others The Emergency Preparedness was updated on 12/29/22, an EPD/EPP meeting was conducted with a plan in place. The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Systemic Changes Public Health notified to have facility placed on the call list and email list for Emergency Preparedness for the community. Monitoring for Compliance The Emergency Preparedness Plan will	

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E 009	Continued From page 4 requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	E 009	be reviewed 1 one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness Plan one time per month X 12 months at QAPI. 01-15-23	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the	E 030		1/15/23

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E 030	Continued From page 5 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication	E 030		

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E 030	Continued From page 6 plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to update the Communication Plan as required in accordance with §483.73(c)(1). Failure to update the Communication Plan could result in incorrect information being utilized in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 2:15 PM revealed that the facility's Communication Plan had not been reviewed and updated in the past 12 months as required. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the	E 030	E030 Corrective Actions 1) AIT and Maintenance Director were educated by E.D. to understand the importance of maintaining the Emergency Preparedness Plan and having the outside entities involved. 2) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others The Emergency Preparedness was updated on 12/29/22, an EPD/EPP meeting was conducted with a plan in place. The Emergency Preparedness Plan will be reviewed 1 time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Systemic Changes	

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E 030	Continued From page 7 requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	E 030	Public Health notified to have facility placed on the call list and email list for Emergency Preparedness for the community. Monitoring for Compliance The Emergency Preparedness Plan will be reviewed 1 time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness' Plan one time per month X 12 months at QAPI. 01-15-23	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E 037		1/15/23

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E 037	Continued From page 8 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 9 expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		

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E 037	Continued From page 10 expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 037		

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E 037	Continued From page 11 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct training of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(1). Failure to conduct training of the EPP could result in inadequate preparedness of staff in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were:	E 037	E037 Corrective Actions 1) AIT and Maintenance Director were educated by E.D. to understand the importance of maintaining the Emergency Preparedness Plan. 2) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. 3) Maintenance Director and/or Designee(s) will audit current and new staff for training in emergency	

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E 037	Continued From page 12 Document review on 12/08/2022 starting at 2:15 PM revealed that the facility did not have documentation available to demonstration that training of employees on the EPP was being conducted at initial hiring or annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	E 037	preparedness policies and procedures Identification of Others The Emergency Preparedness was updated on 12/29/22, an EPD/EPP meeting was conducted with a plan in place. The Emergency Preparedness Plan will be reviewed 1 time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Systemic Changes Public Health notified to have facility placed on the call list and email list for Emergency Preparedness for the community. Monitoring for Compliance The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness' Plan one time per month X 12 months at QAPI. 01-15-23	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039		1/6/23

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	535031	A. BUILDING **01** B. WING _____	**12/08/2022**

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WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE** **RIVERTON, WY 82501**

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E 039	Continued From page 13 (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the	E 039		

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E 039	Continued From page 14 patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039		

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E 039	Continued From page 15 accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an	E 039		

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E 039	Continued From page 16 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from	E 039		

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E 039	Continued From page 17 engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the	E 039		

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E 039	Continued From page 18 LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 19 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 20 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]:	E 039		

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E 039	Continued From page 21 (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct testing of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(2). Failure to conduct testing of the EPP could result in inadequate preparedness of staff in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 2:15 PM revealed that the facility did not have documentation available to demonstration that testing of the EPP had been conducted in the last twelve (12) months. A full-scale exercise shall be conducted annually along with a either a second full-scale exercise, or a table-top exercise. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement.	E 039	E039 Corrective Actions 1) AIT and Maintenance Director were educated by E.D. to understand the importance of maintaining the Emergency Preparedness Plan and having the outside entitles involved. 2) Tabletop exercise held on 12/29/2022 at QAPI to prepare for full-scale exercise to be conducted annually. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others The Emergency Preparedness was updated on 12/29/22, an EPD/EPP meeting was conducted with a plan in place. The Emergency Preparedness Plan will be reviewed on¿ time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Systemic Changes	

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E 039	Continued From page 22 Interview with the Administrator at the time of exit acknowledge the deficiency.	E 039	Public Health notified to have facility placed on the call list and email list for Emergency Preparedness for the community. Monitoring for Compliance The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness' Plan one time per month X 12 months at QAPI. 01-06-23	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA	E 041		1/15/23

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E 041	Continued From page 23 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call	E 041		

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WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE** **RIVERTON, WY 82501**

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E 041	Continued From page 24 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect, test, and maintain the Essential Electrical System (EES) in accordance with §483.73(e). Failure to inspect, test, and maintain the EES could result in a malfunction of	E 041	E041 Corrective Actions 1) AIT and Maintenance Director were educated by E.D. to understand the importance of maintaining and documenting the Essential Electrical	

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	535031	A. BUILDING **01** B. WING _____	**12/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE** **RIVERTON, WY 82501**

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E 041	Continued From page 25 the EES in the event of a power outage. The deficiency affected has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 2:15 PM revealed that the facility did not have proof of low probability of interruption of their natural gas source for their emergency generator. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	E 041	System (EES) preparedness plan. 2) Regional Maintenance Director provided Maintenance Director Education on acquiring proof to show low probability of interruption of natural gas source for the facility. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others The Emergency Preparedness was updated on 12/29/22, an EPD/EPP meeting was conducted with a plan in place. The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Systemic Changes The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. AIT and/or Maintenance Director will attend meetings sponsored by local emergency preparedness groups in the community. Monitoring for Compliance The Emergency Preparedness Plan will be reviewed one time per month at the QAPI meeting. Maintenance Director, ED, and Management staff will be in attendance and review the plan. Audits of Emergency Preparedness' Plan one time per month X 12 months at QAPI. 01-15-23	

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K 000	Continued From page 26	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 12/08/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 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 with a partial basement of Type V(III) construction built in 1965. The building was equipped with a supervised, automatic wet sprinkler system and a zoned fire alarm system. The facility had a capacity of 81 certified Medicare and Medicaid beds with a census of 59 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=E	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire-resistant construction in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain fire-resistant construction could result in the	K 100	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	1/15/23

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K 100	Continued From page 27 spread of fire and smoke, which could result in injury or death in the event of a fire. The deficiency affected the fire-resistant ceiling assembly, and could potentially impact all residents, staff, and visitors in the area. The findings were: Observation on 12/08/2022 at 11:56 AM revealed that the 1-hour fire rated horizontal ceiling assembly was damaged and had not been repaired. Observation of the gypsum board horizontal ceiling assembly in the corridor adjacent to the social services office was sagging and had developed a large crack. Interview with maintenance personnel revealed that a sprinkler pipe located above the ceiling had leaked causing the damage to the gypsum board. Fire-resistant construction shall be continuously maintained. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.1.1.1.3, 4.6.12.1, 4.6.12.2	K 100	statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. K100 Corrective Actions 1) Ceiling assembly will be repaired by 01/15/2023. 2) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others Walking rounds were completed on 12/28/2022 and no other issues were found at that time. Systemic Changes Ceiling scheduled for repairs on 1/2/2023. Maintenance will do walking¿ rounds monthly to check any other areas that may be out of compliance with Life Safety Code. Monitoring for Compliance Audit of walking rounds will be done monthly and brought to QAPI for further discussion and recommendation for at least three months.	
K 200 SS=F	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	K 200		1/15/23

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K 200	Continued From page 28 are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard 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 the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress could delay or inhabit the ability to egress, which could result in injury or death in the event of an emergency requiring evacuation. The deficiency affected multiple exterior exits used by staff, patients, and visitors. The findings were: Observation on 12/08/2022 starting at 12:08 PM, and throughout the survey, revealed multiple exterior exits with snow or ice built up which would impede egress to a public way. Observation of the exterior means of egress to the public way showed that snow had not been plowed and ice had not been removed to allow for the safe evacuation of the facility if needed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	K 200	K200 Corrective Actions 1) Maintenance Director and/or Designee(s) immediately cleared snow and ice from exterior egress doors. 2) Maintenance Director and/or Designee(s) were educated by E.D. on the importance of keeping egress doors cleared of all types of debris to maintain life safety standards. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others All egress doors were checked and cleared by 12/9/2022 and routine checks have been done daily. Systemic Changes Maintenance Director and/or Designee(s) will check egress doors daily and as needed when there is increment weather. Maintenance will do this weekly all year long. Monitoring for Compliance Maintenance Director will keep a weekly log showing documentation o¿ egress doors and bring this log to QAPI every	

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K 200	Continued From page 29 Ref: 2012 NFPA 101 19.2.1, 7.1.10.1	K 200	month to be discussed by the team.	
K 324 SS=E	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 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, document review, and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for the Ventilation Control and Fire	K 324	K324 Corrective Actions 1) Maintenance Director and/or Designee(s) immediately cleaned kitchen hood to be in compliance with state regulations.	1/15/23

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K 324	Continued From page 30 Protection of Commercial Cooking Operations. Failure to properly protect cooking facilities could result in the spread of smoke and fire, which could result in injury or death. The deficiencies affected the kitchen, and could impact all staff within the kitchen. The findings were: Observation on 12/08/2022 at 12:50 PM revealed the facility failed to clean the kitchen hood system as required. Observation revealed that the kitchen hood make-up air vents had collected a large amount of grease. Kitchen hood systems shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. Interview with the maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.6.1, 11.6.2 Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect the kitchen hood extinguishing system as required. Documentation revealed that the kitchen hood extinguishing system had been inspected once in the past twelve (12) months. Kitchen hood extinguishing systems shall be inspected once every six (6) months.	K 324	2) Documentation of hood extinguishing system was obtained and sent to state survey showing proof of inspection within the required time. 3) Maintenance Director and/or Designee(s) were educated on the importance of maintaining the kitchen hood system and to have documentation of cleaning and servicing of kitchen hood and all other required services for kitchen. 4) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others Kitchen Hood was cleaned and documentation was sent to state survey. Systemic Changes Maintenance Director and/or Designee(s) will check kitchen hood every month to maintain a clean and safe system based on Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. System will also be checked and documentation obtained for regular six months maintenance by qualified persons of the kitchen hood extinguishing system as required. Monitoring for Compliance Maintenance Director will keep a weekly log showing documentation of kitchen hood maintenance and bring this log to QAPI every month to be discussed by the team.	

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K 324	Continued From page 31 Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.5 Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect the kitchen hood exhaust and duct system as required. Documentation revealed that the kitchen hood exhaust and duct system had been inspected once in the last twelve (12) months. Kitchen hood exhaust and duct system shall be inspected once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.4	K 324		
K 345 SS=F	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	K 345		1/6/23

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K 345	Continued From page 32 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 the fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to activate the fire alarm system as required. Documentation revealed that the fire alarm system had not been activated since April of 2022. Fire alarm systems shall be activated every month. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(24)	K 345	K345 Corrective Actions 1) Maintenance Director and/or Designee(s) educated by the Regional Maintenance Director on testing and maintaining the fire alarm system monthly and keeping logs available of fire alarm system batteries and load voltage testing. 2) Documentation of fire alarm system batteries and load voltage inspection was provided to state survey on 12/14/2022. 3) Fire alarm system was activated on 12/22/2022 to keep compliance with regulations related to National Fire Alarm and Signaling Code. 4) Maintenance Director and or design e tested the waterflow and supervisorysignal. 5) An AdHoc QAPI meeting was held in December 29th, 2022 to discuss this POC and its adaptation. Identification of others Documentation was obtained and sent to state survey related to fire alarm system maintenance. Fire alarm system was activated and training exercise was done on 12/22/2022 for all employees present. Systemic Changes Maintenance Director and/or Designee(s) will make sure documentation is available at all times related to the fire alarm system. Maintenance Director and/or Designee will activate the, fire alarm system monthly	

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K 345	Continued From page 33 Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect and test the fire alarm system batteries as required. At the time of the survey no documentation was available to show that the fire alarm system batteries had been inspected and load voltage tested in the past twelve (12) months. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to test the water flow alarm and the supervisory signal as required. Documentation revealed that the last time either test was conducted was April of 2022. These tests shall be conducted once every quarter. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010	K 345	and document. Monitoring for Compliance Maintenance Director will keep a monthly log showing documentation of fire alarm system activation, water flow, supervisory signal and bring these logs to QAPI every month to be discussed by the team. 01/6/23	

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K 345	Continued From page 34 NFPA 72 Table 13.2.6.1; 2011 NFPA 25 5.1.1.2, 5.3.3.1, 5.3.2	K 345		
K 353 SS=F	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 test and maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system, and has the potential to affect all residents, staff, and visitors.	K 353	K353 Corrective Actions 1) Documentation of Water-Based Fire Protection System inspection was provided to state survey on 12/14/2022. 2) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others Documentation was obtained and sent to state survey related to Water¿Based Fire Protection System. Systemic Changes	1/15/23

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K 353	Continued From page 35 The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect and test the backflow preventer associated with the fire sprinkler system. No documentation was available at the time of the inspection to indicate that the backflow preventer had been inspected in the past twelve (12) months. Backflow preventers associated with the fire sprinkler system shall be tested annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.5.1, 9.7.1.1; 2011 NFPA 25 13.6.2.1	K 353	Maintenance Director and/or Designee(s) will make sure documentation is available at all times related to the Water-Based Fire Protection System. Monitoring for Compliance Maintenance Director will keep a log showing documentation of Water¿Based Fire Protection System and bring to QAPI during the month the inspection was completed.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 10,	K 355	K355 Corrective Actions 1) Both fire extinguishers were immediately inspected. 2) Maintenance Director and/or	1/15/23

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WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE** **RIVERTON, WY 82501**

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K 355	Continued From page 36 Standard for Portable Fire Extinguishers. Failure to properly inspect and maintain portable fire extinguishers could result in the fire extinguishers working improperly, which could result injury or death in the event of a fire. The deficiency affected two (2) of multiple portable extinguishers in the facility, and has the potential to affect all residents, staff, and visitors. The findings were: Observation on 12/08/2022 at 12:48 PM revealed two portable extinguishers, including the kitchen stove K-type extinguisher, located in the facility's kitchen area. Observation of the tags on the extinguishers revealed that they had not been inspected since February of 2022. Portable extinguishers shall be inspected every month. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.5.5.12, 9.7.4.1; 2010 NFPA 10 7.2	K 355	Designee(s) were educated by the E.D. the importance of monthly inspections of fire extinguishers 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others All fire extinguishers were inspected and no other fire extinguishers were out of date_ Systemic Changes Maintenance Director and/or Designee(s) will inspect fire extinguishers monthly and keep a log, including in the kitchen. Monitoring for Compliance Maintenance Director will keep a log showing documentation of Fire Extinguisher Inspections and bring to QAPI every month for 3 months to discuss with the team.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		1/15/23

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K 521	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the HVAC system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect and test the fire dampers associated with the HVAC system as required. No documentation was available at the time of the inspection to indicate when the last time the fire dampers had been tested and inspected. Fire damper shall be inspected and tested once every four (4) years. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency.	K 521	K521 Corrective Actions 1) Maintenance Director contacted HVAC to set of inspection and testing of the fire dampers associate, with the HVAC system on 12/29/2022. 2) Maintenance Director and/or Designee(s) were educated by the E.D. the importance of monthly inspections of fire dampers and maintaining copies of documentation of these inspections. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others Since unable to find previous inspections of fire dampers, Maintenance Director set up a new inspection to be done by 1/10/2023. Systemic Changes Maintenance Director will maintain records of inspection of the fire dampers and make available at all times. Monitoring for Compliance Maintenance Director will bring copy of services of fire dampers to QAPI o discuss compliance and continue to bring to QAPI when fire dampers an: serviced to prove records are being logged.	

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K 521	Continued From page 38 Ref: 2012 NFPA 101 19.5.2, 9.2.1, 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in the improper response from residents, staff, and visitors in the event of a fire, which could result in injury or death. The deficiency affected all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed facility failed to conduct fire drills as required. Documentation revealed that the facility had last conducted a fire drill in April of 2022. Fire drills shall be conducted quarterly on each shift to familiarize staff with the signals and emergency action required. Interview with maintenance personnel and Administrator revealed that they	K 712	K712 Corrective Actions 1) Fire drill was done on 12/22/2022. 2) Maintenance Director and/or Designee(s) were educated by the E.D. the importance of monthly fire drills and maintaining documentation to be available at all times. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others No records were found of recent fire drills. Systemic Changes Maintenance Director will keep logs of fire drills that will be conducted every month on both shifts and as needed to keep new staff up to date. Monitoring for Compliance Maintenance Director will bring fire drill logs to QAPI and/or Life Safety meetings every month	1/15/23

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K 712	Continued From page 39 believed fire drills were being conducted as required, but were not being documented. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	to be discussed.	
K 761 SS=F	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 inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test	K 761	K761 Corrective Actions 1) Maintenance Director and/or Designee(s) inspected Fire Door Assemblies. 2) Maintenance Director and/or Designee(s) were educated by the E.D.	1/15/23

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K 761	Continued From page 40 fire door assemblies could result in the spread of smoke and fire, which could result in injury or death in the event of a fire. The deficiency affected all fire rated doors, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect and test fire door assemblies as required. Documentation revealed that the fire door assemblies had not been inspected in the past twelve (12) months. Fire door assemblies shall be inspected and tested annually by qualified personnel. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761	the importance of monthly checks on fire door assemblies. 3) An AdHoc QAPI meeting was held on December 29th, 2022 to discuss this POC and its adaptation. Identification of Others All fire door assemblies were inspected and are in working order. Systemic Changes Maintenance Director and/or Designee(s) will inspect or have inspected the fire door assemblies annually and maintain copies of inspection to be available at all times. Monitoring for Compliance Maintenance Director will bring copy of fire door inspection to QAPI annually to discuss with the team.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at	K 914		1/15/23

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K 914	Continued From page 41 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain electrical receptacles in accordance with the 2012 NFPA 99, Health Care Facilities. Failure to properly test and maintain electrical receptacles could result in a failure of the receptacles, which could injury or death. The deficiency affected all electrical receptacles in the patient bed locations, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to test all non-hospital grade receptacles at patient bed locations as required. No documentation was available at the time of the survey to show that testing of the non-hospital grade receptacles at patient bed locations had been conducted in the past twelve months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the	K 914	K914 Corrective Actions Maintenance Director and/or Designee will inspect all non-hospital grade receptacles at patient bed locations by date of compliance. Identification of Others No logs have been found of inspection of receptacles has been found. Systemic Changes Maintenance Director and/or Designee will inspect all non-hospital grade receptacles at patient bed locations and keep logs annually. Monitoring for Compliance Initial inspection will be brought to QAPI for 90 days for discussion and further recommendations.	

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K 914	Continued From page 42 requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.3.4.1.3	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		1/6/23

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K 918	Continued From page 43 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, which could result in injury or death in the event of an emergency. The deficiencies affected the EES, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to test the emergency electrical generator lead-acid batteries as required. No documentation was available at the time of the survey to show that the specific gravity, or conductance, was being testing on the emergency electrical generator batteries. Lead-acid batteries associated with the emergency electrical generator shall be tested monthly for either specific gravity or for conductance . Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit	K 918	K918 Corrective Actions Current log of emergency electrical generator battery testing was found and will be provided to state survey. Regional Maintenance Director provided Maintenance Director education on acquiring proof to show low probability of interruption of natural gas source for the facility. Identification of Others Logs are in compliance with state guidelines. Systemic Changes Maintenance will continue to maintain logs of emergency generator test and make log available at all times. Monitoring for Compliance Maintenance Director will' bring logs to QAPI monthly for three months for discussion and further recommendations. 01/06/23	

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K 918	Continued From page 44 acknowledge the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.3.7.1 Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to inspect the emergency electrical generator as required. Documentation reveal that the emergency electrical generator had last been inspected in April of 2022. Emergency electrical generators shall be inspected weekly. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.4 Document review on 12/08/2022 starting at 1:20 PM revealed the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. No documentation was available at the time of the survey to provide proof from the natural gas provider of the reliability of the natural gas service. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement.	K 918		

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K 918	Continued From page 45 Interview with the Administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	K 918		