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 _____	**03/13/2024**

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 03/13/2024. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/13/2024. 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 56 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=F	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.	K 100		4/19/24

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

Electronically Signed | 04/06/2024

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K 100	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire-resistive construction in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain fire-resistive construction could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected two (2) of six (6) smoke compartments and has the potential to affect all residents, staff, and visitors. The findings were: Observation on 03/13/2024 at 11:31 AM and 12:05 PM revealed that the fire-resistive horizontal assembly protecting the roof structure was not being maintained. Observation of resident rooms 35 and 20 revealed large portions of the ceiling drywall had been removed. The facility construction type is V(111), and the ceiling drywall is used as the 1-hour fire resistive construction to protect the roof structure above. Interview with maintenance personnel revealed that the ceiling drywall had been removed due to water leaks in roof. The facility is working with the roofing contractor to fix the leaking roof, and then will have a contractor repair the ceiling. Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated 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	K 100	K100 Corrective Action Drywall to be completed. Identification of Others Initial audit completed by ED/Designee of other rooms maintaining fire-resistive construction. Systemic Changes Education provided by the ED to current staff related to maintaining fire-resistive construction. Ongoing audits completed by the ED/Designee weekly for three months to assess for maintenance of fire-resistive construction. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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

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K 232	Continued From page 2	K 232		
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress width in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress width could result in a slow, or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected one (1) of multiple corridors used by staff, patients, and visitors. The findings were: Observation on 03/13/2024 at 10:50 AM revealed multiple chairs located in the corridor adjacent to the main entrance. Observation of the corridor revealed multiple chairs located on one side of the corridor projecting approximately 2 feet into the corridor's 8 foot width. The chairs were not secured to the floor or wall. All corridors are protected by an electronically supervised automatic smoke detection system. It was also observed that multiple chairs and furniture were located in the main entrance, which is approximately 10 feet in width. Recliner type chairs were located on both sides of the corridor	K 232	K232 Corrective Action Corridor near the front entrance has been rearranged and means of egress is now in compliance. Identification of Others Initial audit completed by ED/Designee of egress for compliance with safety codes. Systemic Changes Education provided by the ED to current staff related to means of egress width. Ongoing audits completed by the ED/Designee weekly for three months to assess safety by means of egress. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	4/19/24

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K 232	Continued From page 3 reducing the clear width to approximately 5 feet. Where corridors are 8 feet in width, fixed furniture that is securely attached to the floor or wall, and do not reduce the clear corridor width to less than 6 feet may, be permitted. Interview with the maintenance manager at the time of observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.2.3.4(5)	K 232		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress exit signs in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress exit signs could result in a slow or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected several corridors used by staff, patients, and visitors.	K 293	K293 Corrective Action Electrician out to fix or replace all exit signs. All signs illuminated. Identification of Others Initial audit completed by ED/Designee for other sign affected. Exit signs fixed or replaced. Systemic Changes Education provided by the ED to current	4/19/24

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K 293	Continued From page 4 The findings were: Observation on 03/13/2024 starting at 11:37 AM, and throughout the survey, revealed multiple exit signs throughout the facility that were not illuminated. Observation revealed that some of the signs were not illuminated due to burnt out bulbs. Through interview it was determined that the electric wiring to the other LED type exit signs had not completed. Interview with maintenance personnel revealed that the facility was working with a contractor to have the electric wiring to the exit signs corrected. Interview with the maintenance manager at the time of observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.2.3.4(5)	K 293	staff related to maintaining the means of egress exit signs. Ongoing audits completed by the ED/Designee weekly for three months to assess safety by means of egress exit signs. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	
K 321 SS=E	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	K 321		4/19/24

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K 321	Continued From page 5 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 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 protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in the spread of fire and smoke, resulting in injury or death. The deficiency affected one (1) hazardous room and has the potential to affect all residents, staff, and visitors in the vicinity of the affected area. The findings were: Observation on 03/13/2024 at 11:28 AM revealed that the facility failed to maintain the smoke resistance of the hazardous area. Observation of the clean utility room adjacent to the north wing nurse's station revealed a large hole in the wall that opens to the nurse's station area. Interview with maintenance personnel revealed that	K 321	K321 Corrective Action Smoke resistance of the hazardous area in the clean utility room has been fixed. Identification of Others Initial audit completed by ED/Designee of other walls for maintenance of smoke resistance of hazardous areas in the facility. Systemic Changes Education provided by the ED to current staff related to maintaining the smoke resistance of hazardous areas. Ongoing audits completed by the ED/Designee weekly for three months to assess for maintenance of smoke resistance of hazardous areas. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly	

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K 321	Continued From page 6 plumbing to a sink in the nurse's station was being fixed, which was the reason for the hole in the wall. Hazardous areas shall be separated from other spaces by smoke partitions which resist the passage of smoke. Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.1.2	K 321	for at least three months for further recommendations.	
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:	K 353		4/19/24

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K 353	Continued From page 7 Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 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 malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Observation on 03/13/2024 at 2:00 PM revealed that the facility failed to maintain the sprinkler system as required. Observation of the sprinkler system in the facility's roof structure revealed multiple flexible HVAC ducts that were resting on the sprinkler piping. Sprinkler piping shall not be subject to external loads by materials either resting on the pipe or hung from the pipe. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 5.2.2.2	K 353	K353 Corrective Action Maintenance of the sprinkler system was performed, and all sprinklers are free from any HVAC hoses. Identification of Others Initial audit completed by ED/Designee of other sprinklers for maintenance of any external loads that may affect the function of the sprinklers. Systemic Changes Education provided by the ED to current staff related to maintenance of the sprinkler system. Ongoing audits completed by the ED/Designee weekly for three months to assess maintenance of the sprinkler system. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	
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	K 761		4/19/24

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K 761	Continued From page 8 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 fire door assemblies could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected all fire door assemblies, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/2024 starting at 12:50 PM revealed that the facility failed to inspect and test fire door assemblies as required. Documentation was available at the time of the survey to demonstrate that the fire door assemblies in the facility had been inspected and tested in the last 12 months, however, the person who conducted the inspection and testing had not received any training or certification in inspection and testing of fire door assemblies. Fire door assemblies shall be inspected by a qualified	K 761	K761 Corrective Action Inspection and testing of fire door assemblies have been inspected by a qualified person with training. Identification of Others Initial audit completed by ED/Designee of fire doors has been completed. Systemic Changes Education provided by the ED to current staff related to inspection and testing of fire door assemblies. Ongoing audits completed by the ED/Designee weekly for three months to assess for maintenance of fire door assemblies. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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K 761	Continued From page 9 person with training or experience that demonstrates ability. Interview with maintenance personnel at the time of observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761		
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	K 918		4/19/24

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K 918	Continued From page 10 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 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 Code, 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, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/2024 starting at 11:50 AM revealed that the facility failed to perform the 4-hour load test of the emergency generator. No documentation was available at the time of the survey to demonstrate that the facility had conducted a 4-hour load test of the emergency generator within the last 36 months. Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit	K 918	K918 Corrective Action TWE scheduled for 4-hour load test. Testing to be completed. Identification of Others Initial audit completed by ED/Designee of essential electrical system (EES) maintained. Systemic Changes Education provided by the ED to current staff related to essential electrical system (EES). Ongoing audits completed by the ED/Designee weekly for three months to assess for maintenance of essential electrical system (EES). Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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K 918	Continued From page 11 acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9 Document review on 03/13/2024 starting at 12:50 AM revealed that the facility failed to perform the monthly battery specific gravity or conductance test on the emergency generator batteries. No documentation was available at the time of the survey to demonstrate that the facility had conducted the monthly battery specific gravity or conductance test on the emergency generator in the last twelve months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.3.7.1	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		4/19/24

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

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K 920	Continued From page 12 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize power strips could result in Patient Care Related Electrical Equipment (PCREE) working improperly, resulting in injury or death in the event of a malfunction. The deficiency affected four (4) of multiple resident rooms and could potentially affect the residents of those rooms. The findings were: Observation on 03/13/2024 starting at 11:20 AM revealed power strips located in patient care areas while PCREE was present. Observation of resident rooms 4, 33, 24, and 19 revealed power strips in the resident care area with a concentrator present. Power strips shall not be located in the resident care area when PCREE is present. Interview with maintenance personnel at the time of observation acknowledge the deficiency, and	K 920	K920 Corrective Action All Power strips in rooms 4, 33, 24, and 19 are free from Patient Care Related Electrical Equipment (PCREE). Extension cord in boiler room has been removed. Identification of Others Initial audit via ECR rounds completed and deficient practices have been corrected. Systemic Changes Education provided by the ED to current staff related to power cords and Patient Care Related Electrical Equipment (PCREE) is maintained. Ongoing audits completed by the ED/Designee weekly for three months to assess for maintenance of Patient Care Related Electrical Equipment (PCREE). Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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 _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 13 indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC Observation on 03/13/2024 at 10:41 AM revealed extension cords being utilized as permanent means of supplying power. Observation of the boiler room located in the facility's basement revealed extension cords being utilized as a substitute for fixed wiring. Extension cords can only be utilized temporarily and must be removed as soon as the purpose is completed. Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 10.2.4	K 920		