STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 12/12/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an	E 024		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/14/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING **01** B. WING _____	**12/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	**890 US HWY 20 SOUTH** **BASIN, WY 82410**

(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 024	Continued From page 1 emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a policy or procedure for use of volunteers as required in accordance with §483.73(b)(6). Failure to provide a policy or procedure for use of volunteers could result in inadequate preparedness in the event of emergency staffing needs. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 12/12/2024 starting at 12:30 PM revealed that the facility did not have documentation available to demonstration they had a policy or procedure for addressing the use of volunteers in an emergency. A policy or procedure shall be provided for the process and role of integration of State and Federally designated health care professionals to address surge needs during an emergency. Interview with administrative staff at the time of the observation confirmed the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency.	E 024	E024 Policies/Procedures-Volunteers and Staffing WRC acknowledges the failure to provide a policy or procedure for use of volunteers. The facility understands inadequate preparedness in the event of emergency staffing needs could potentially affect all residents, staff, and visitors. WRC has developed an "Emergency Volunteers" policy to be included in the facility Emergency Preparedness Plan The policy has been reviewed and approved by the QAPI committee on 1/13/25	1/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 12/12/2024. 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 of Type II (000) construction, with a basement, built in 1981. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 90 certified Medicare and Medicaid beds with a census of 79 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 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 in the event of a fire. The deficiency affected the dining area, and had the potential to affect residents, staff, and visitors in the area. The findings were: Observation on 12/12/2023 at 11:29 AM revealed a hazardous storage area that was not properly protected. Observation of the main dining area revealed an adjacent alcove that was being utilized for storage of combustible materials including cardboard boxes and kitchen equipment. Areas being used to store combustible materials shall be separated from other spaces by smoke partitions and the doors shall be self- or automatic-closing	K 321	K321 Hazardous Areas- Enclosure WRC acknowledges the observation of hazardous combustible materials stored in a unprotected area. The area observed is not intended to be a hazardous storage area. The area has been cleared and an audit created to ensure it remains in compliance. The audit will be conducted once a week for 2 months then 1 time monthly for an additional 3 months. Results of the audit will be reported to the QAPI monthly meeting for review and recommendations until substantial compliance is reached	area cleared 12/17/24 audits begin 1/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 Interview with the maintenance director at the time of the observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.3.2.1.2	K 321		
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 an improper response by staff to an emergency, resulting in injury or death. The deficiency had the potential to affect all residents, staff, and visitors. The findings were:	K 712	K712 Fire Drills WRC acknowledges the failure to properly conduct fire drills quarterly during each shift. The facility recognizes the results of this deficient practice could potentially affect all residents, staff, and visitors. WRC has updated the Monthly Fire Drill Time and Schedule to include all shifts quarterly Maintenance manager will continue to track dates and times of all fire drills and report them to the monthly QAPI meeting and quarterly safety meeting.	1/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 5 Document review on 12/12/2024 starting at 1:08 PM revealed that the facility failed to conduct all required night-shift fire drills. Documentation was available at the time of the survey to demonstrate that the facility was conducting monthly fire drills, however, it revealed that the night-shift between 6:00 PM and 6:00 AM had only conducted a fire drill twice in the last twelve (12) months. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with the maintenance director at the time of the observation confirmed the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712		

Wyoming Retirement Center
Policies and Procedures

SUBJECT: Emergency Volunteers	**Policy No.** WRC-80
Date Issued: January 13, 2025	**Revised/Reviewed:**

REVISION HISTORY

Date	Change	Reference Section(s)

PURPOSE

This policy establishes procedures for screening, credentialing, training, assignment, and supervision of volunteers to augment facility staff during medical surge and events that exceed staff capability.

The purpose of instituting policies and procedures regarding emergency volunteers is to:

- Provide a mechanism for the coordinated receipt, management and integration of volunteers into community emergency operations;
- Control risk to minimize liability for the services of volunteer medical professionals and other volunteers through appropriate management procedures and by maintaining general liability insurance, workers' compensations insurance, and professional liability as appropriate; and

- Prevent injury to staff and volunteers who are responding to emergencies and secondary injury to individuals who are emergency or disaster victims.

POLICY

1. In the event of public emergency, determine the need for volunteers
2. Request volunteers
    a. Include the anticipated role of personnel being requested and desired licensure/certifications. Understanding the role of the volunteer will help appropriately fill the request, and enables a search for a suitable substitute if the individual(s) with specific desired qualifications are not available.
    b. When making resource requests, healthcare facilities should employ the "SALT" resource requesting approach to ensure requests are thorough, effective and

appropriate.

i. Be **S**pecific
ii. Specify **A**mount
iii. Include **L**ocation
iv. Consider **T**ime

c. The facility will determine how to best use / manage all volunteers.
d. If utilizing the services of the ESAR-VHP or WAVES volunteers will be matched to the needs and requests and deployed to the facility. (Credentials for these volunteers may have been previously certified, however will need to be verified by the utilizing facility.)
e. The facility assumes responsibility for basic needs of emergency volunteers including food, lodging, personal and medical care needs.

3. Establish a volunteer check in area with a lead Emergency Volunteer Registration - All emergency volunteers shall register on arrival in the Volunteer Management Center.
    a. Verification of Identification - Volunteers will be required to present valid government-issued photo identification and at least one of the following:
    b. A current community picture identification card that clearly identifies professional designation;
    c. Documentation of a current active license, certification, or registration;
    d. Primary source verification of licensure, certification, or registration; with verification being completed by facility through the Wyoming state board https://wsbn.wyo.gov/
    e. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), or part of the state Wyoming WAVES registry for medical and health professionals (ESAR-VHP), or other state or federal organizations;
    f. Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render resident care, treatment, and services in disaster circumstances;

4. Assignment after initial ID verification, general facility orientation, and registration, the volunteer will be sent to the general staffing pool, the nursing staffing pool, or to the Medical Staff Director, depending on the volunteers presented qualifications. Volunteer assignment will be matched appropriately with the licensure and credentials required to operate within the assigned facility and position.

5. Volunteer Supervision Department Director or designee oversees the performance of each volunteer practitioner. Oversight will include:

    a. Direct observation
    b. Mentoring
    c. Monitoring
    d. Clinical record review

6. Volunteers may assist with resident care only under the direct supervision of designated personnel who will be available to provide appropriate resident care assignments, give

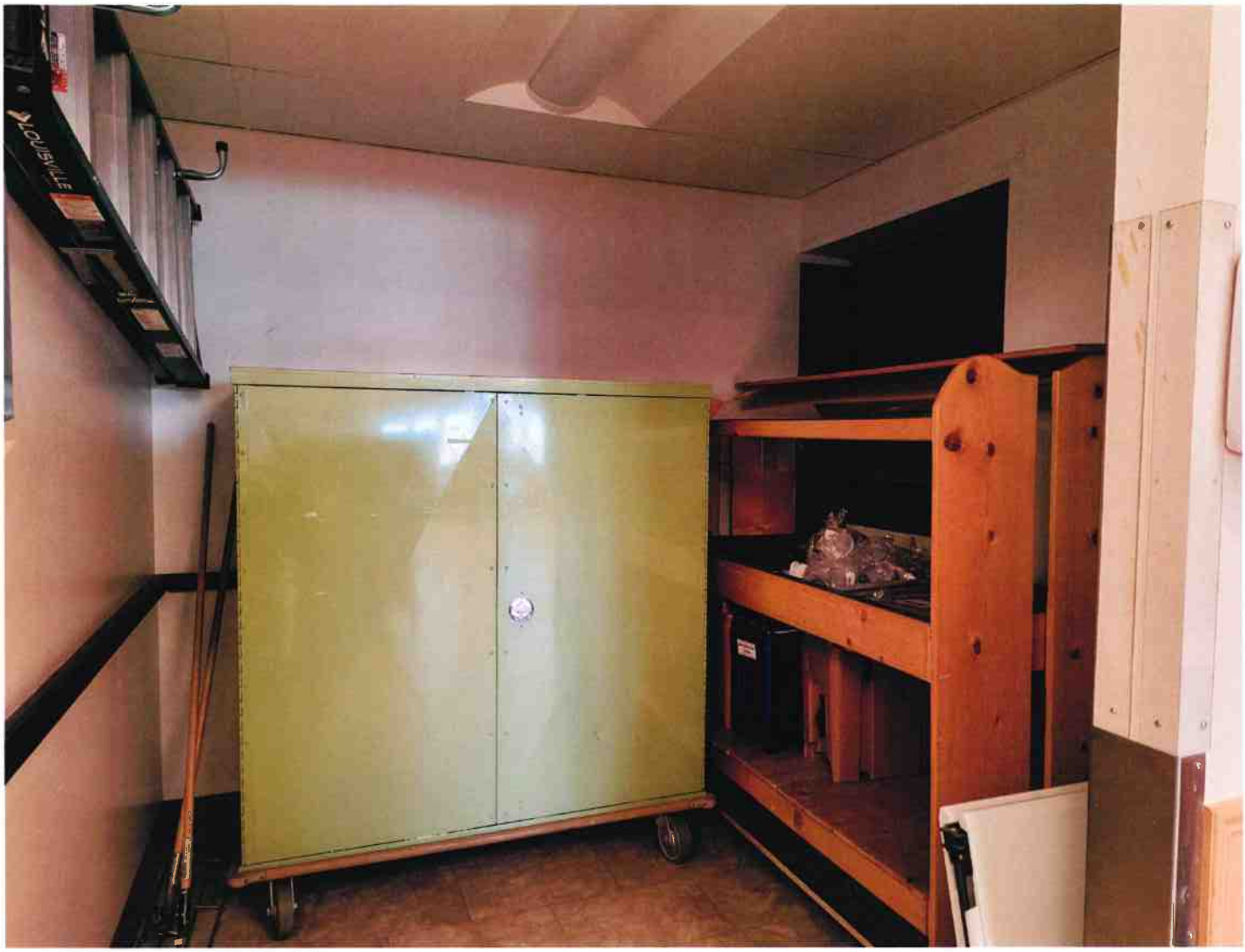
necessary clinical direction, and monitor care provided by the volunteer.

7. Non-clinical and unaffiliated volunteers will only work in general assistance areas like runners with information and delivery of supplies, or in communications under the direction and supervision of community employees.
8. The maximum an employee can be asked to work is 16 hours with 8 hours off between shifts. The community will provide support for employees wishing to remain at the facility awaiting their next shift.

REFERENCES AND RESOURCES

Approved:

Administrator	(Date)	Department Lead	(Date)


LOUISVILLE

Monthly Fire drill Time and Schedule

Month	Department	Shift	Date	Time
January Silent Drill	Office	6am-6pm 6pm-6am		
February	Dietary	6am-6pm		
March	Nursing south	6am-6pm		
April Silent Drill	Maintenance	6am-6pm 6pm-6am		
May	Activities	6am-6pm		
June	Nursing north	6am-6pm		
July Silent Drill	Office	6am-6pm 6pm-6am		
August	Nursing South	6pm-6am		
September	Dietary	6am-6pm		
October	Nursing	6am-6pm		
November Silent Drill	Environmental Service	6am-6pm 6pm-6am		
December	Nursing North	6pm-6am		

Hazardous Area - Enclosure Area

	Inspect once a week for 2 months and 1 time monthly for 3 months
Date	Area Inspected - Alcove adjacent to Dinning Room