STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**05/04/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on May 03, 2018. Requirements for Long Term Care Facilities Section 42 CFR 483.70(a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (000) construction with a basement built in 1954 with additions of the same construction type built in 1985 and 1990. The building was equipped with a supervised, automatic wet sprinkler system and a zoned fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 43 residents.	K 000		
K 200 SS=E	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by:	K 200		5/24/18

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

Electronically Signed | 05/23/2018

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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K 200	Continued From page 1 Based on observation and staff interview the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress could result in injury or death in the event of an emergency requiring evacuation from an area. The deficiencies affected three (3) of three (3) smoke compartments on the main floor, and the basement floor. The findings were: Observation on 05/03/18 at 10:50 AM in the basement revealed two rooms with signs applied to the doors that read "Not An Exit" in lieu of the required "NO EXIT" verbiage. Interview with the maintenance director at the time of the observation acknowledged the deficiency, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. Reference: 2012 NFPA 101 Section 19.2.1, 7.10.8.3 Observation on 05/03/18 at 11:11 AM and throughout the survey revealed multiple exterior doors equipped with delayed-egress locks with signage located below the door window, and behind the crash bar. The location and color of the delayed-egress signs made them difficult to read. Delayed-egress signs shall be readily visible and on a contrasting background. Interview with the maintenance director at the	K 200	1. The facility will ensure that all doorways that are not designated as exits are labeled with the appropriate signage. Facility will also ensure that all delayed-egress signs are readily visible and on a contrasting background. 2. All residents are affected. Three (3) of three (3) smoke compartments on the main floor and the basement affected. 3. 3 doors not designated as exits had the proper signage posted on 5/23/18. The facility was audited for any further doors not designated as exits on 5/4/18 and found no further discrepancies. Upon initial audit on 5/4/18, 8 (eight) Delayed-egress doors were found without signage readily visible and on a contrasting background. All eight doors had signage applied that is readily visible and on a contrasting background on 5/23/18. On 5/23/18 Executive Director educated Maintenance Manager on the regulation that requires appropriate signage on doors not designated as exits as well as the requirement that delayed-egress doors have signage readily visible and on a contrasting background. 4. The facility will incorporate auditing of appropriate door signage as part of the facility's weekly preventative maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	

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K 200	Continued From page 2 time of the observation acknowledged the signs were difficult read, and revealed that he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiencies. Reference: 2012 NFPA 101 Section 19.2.2.2.4, 7.2.1.6.1	K 200		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler 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	K 321		5/24/18

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K 321	Continued From page 3 (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 protect hazardous areas could result in injury or death in the event of a fire. The deficiencies affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/03/18 at 11:10 AM revealed resident room 27 was being used as a storage room, and the door was not provided with a self-closing or automatic-closing device. Interview with the maintenance director at the time of the observation acknowledged the room was being used as a storage area but was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1, 19.3.2.1.3	K 321	1. The facility will ensure that all doors requiring an auto-closer have one installed in accordance with state and federal regulation. 2. All residents are affected. One (1) of three (3) smoke compartments on the main floor affected. 3. The door on room #27 had an auto-closer installed on 5/17/18. The facility was fully audited on 5/4/18 for any other doors that require an auto-closer and no other discrepancies were found. On 5/23/18 the ED educated the Maintenance Manager on the Life Safety requirements of auto-closers on room doors being used as storage. 4. The facility will incorporate auditing of all facility doors requiring auto-closers into facility weekly preventive maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		5/24/18

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K 324	Continued From page 4 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 documentation staff review and staff interview the facility failed to maintain the kitchen range hood in accordance with the 2012 NFPA 10, Life Safety Code and NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to maintain the kitchen range hood could result in injury or death in the event of a fire. The deficiency affected one (1) of three (3) smoke compartments on the main floor. The findings were: Documentation review on 05/03/18 at 12:30 PM revealed that the kitchen range hood had been inspected and cleaned once in the last twelve months. Kitchen range hoods shall be inspected	K 324	1. The facility will ensure that the kitchen hood is cleaned by an outside contractor twice yearly in accordance with state and federal regulation. 2. All residents are affected. One (1) of three (3) smoke compartments on the main floor affected. 3. Facility had the initial hood cleaning completed on 2/25/18 and has scheduled contractor to clean hood again on 8/25/18. On 5/23/18 ED educated Maintenance Manager on the requirement to have the kitchen hood cleaned by an approved contractor twice yearly. 4. The facility will incorporate auditing of biannual kitchen hood cleaning into facility preventive maintenance program. Audit	

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K 324	Continued From page 5 and cleaned once every six months. Interview with the maintenance director at the time of the documentation review acknowledged the deficiency, and that he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 11.4	K 324	results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of an emergency. The deficiency affected three (3) of three (3) smoke compartments on the main floor, and the basement. The findings were:	K 345	1. The facility will ensure that the Fire Alarm System will be tested and maintained on a monthly basis. The facility will also ensure that the fire panel backup battery system is inspected and load tested twice yearly in accordance with state and federal regulation. Finally, the facility will ensure that smoke detector sensitivity testing is performed once every two years. 2. All residents are affected. Three (3) of three (3) smoke compartments on the	5/24/18

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K 345	Continued From page 6 Documentation review on 05/03/18 at 12:30 PM revealed that the facility had activated the fire alarm system once every month from October 2017 thru April 2018, but had no additional documentation demonstrating that the fire alarm had been activated each month for the 12 months prior to the survey. Interview with the maintenance director at the time of observation acknowledged the missing documentation. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(24) Documentation review on 05/03/18 at 12:30 PM revealed that the facility had the sealed lead acid batteries of the fire alarm system inspected once in the previous twelve months. The sealed lead acid batteries shall be inspected at least once every six months. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated that he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.3.1(3) Documentation review on 05/03/18 at 12:30 PM revealed that the facility performed the load voltage test on the batteries for the fire alarm	K 345	main floor as well as basement affected. 3. Facility had approved contractor test and maintain fire alarm system on 5/2/18. This will be done by Maintenance Manager/designee on a monthly basis going forward. Contractor also performed initial biannual inspection and load test on battery backup system for fire alarm system on 5/2/18. Contractor has been scheduled to perform second biannual inspection and load test on battery backup system for fire alarm system on 11/2/18. On 5/17/18 contractor tested smoke detector sensitivity and is scheduled to repeat testing on 5/17/20. On 5/23/18 ED educated Maintenance Manager on the requirement to test and maintain fire alarm system on a monthly basis, have the fire panel battery backup system inspected and load tested twice yearly and have smoke detector sensitivity testing performed once every two years. 4. The facility will incorporate auditing of Fire Alarm System monthly testing and Fire Panel battery backup system inspections/load tests into facility preventive maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	

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K 345	Continued From page 7 system once in the last twelve months. The load voltage test shall be performed at least once every six months. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5.6(a)(3) Documentation review on 05/03/18 at 12:30 PM revealed that the facility had not performed a smoke detector sensitivity test within the previous two years. Smoke detector sensitivity testing shall be performed at least once every two years. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5.15(i)	K 345		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511		5/24/18

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K 511	Continued From page 8 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and NFPA 70, National Electrical Code. Failure to maintain clearance to electrical equipment could result in injury or death in the event of an emergency. The deficiencies affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/03/18 at 10:55 AM revealed an electrical disconnect. Additional observation revealed items stored adjacent to the disconnect, which interfered with the required clearance and access space. Interview with the maintenance director at the time of the observation acknowledged that clearance to the electrical disconnect was being blocked, and indicated that he was aware of the requirement but unaware of the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Observation on 05/03/18 at 11:00 AM in the linen closet, located next to the dietitian office, revealed storage in front of several electrical	K 511	1. The facility will ensure that all Power Shut offs in the building are easily accessible and free from obstruction. 2. All residents are affected. One (1) of three (3) smoke compartments on the main floor affected. 3. The kitchen and linen closet area were rearranged on 5/4/18 to ensure unobstructed access to power shut offs in both locations. Red tape was used to mark off areas to be left unobstructed on 5/4/18. The building was audited on 5/4/18 to ensure all power shut offs are easily accessible and free from obstruction and no further discrepancies were found. On 5/23/18 ED educated Maintenance Manager on the requirement that all power shut offs in the building must be easily accessible and free from obstruction. 4. The facility will incorporate auditing of accessibility to power shut offs as part of the facility's weekly preventative maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	

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K 511	Continued From page 9 panels which limited access and visibility. Interview with the maintenance director at the time of the observation acknowledged that clearance to the electrical equipment was being blocked, and indicated that he was aware of the requirement, but unaware of the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1, 9.1.2; 2011 NFPA 70 110.26(A)	K 511		
K 521 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and the 2010 NFPA 80, Standard for Fire Doors and other Opening Protectives. Failure to test and maintain the HVAC system could result in injury or death by allowing the propagation of smoke during a fire.	K 521	1. Upon inspection of HVAC system by contractor on 5/17/18 it was revealed that no smoke dampers exist in the building's HVAC system. The facility knows there are no smoke dampers by maintaining documentation verifying these findings. In the event the facility employs smoke dampers they will be tested and maintained at least every 4 years. 2. All residents affected. Three (3) of	5/24/18

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K 521	Continued From page 10 The deficiency affected three (3) of three (3) smoke compartments on the main floor. The findings were: Documentation review on 05/03/18 at 12:30 PM revealed that the facility had not performed the required smoke damper testing within the previous four years. Smoke dampers shall be tested at least once every four years. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated that he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 9.2.1; 2012 NFPA 90A 5.4.8.2; 2010 NFPA 80 19.4.1.1	K 521	three (3) smoke compartments on the main floor affected. 3. On 5/17/18 contractor determined that the facility does not employ smoke dampers and this was documented in a statement made by the contractor in his report. On 5/23/18 ED educated Maintenance Manager on the requirement to have HVAC smoke dampers tested and maintained at least once every four years. 4. In the event the facility employs HVAC smoke dampers the facility will incorporate auditing of smoke dampers into facility weekly preventive maintenance program and audits will be brought to monthly QAPI Meeting. In the meantime the facility will keep the contractor's report on file with all fire alarm documentation. 5. The ED is responsible for compliance.	
K 712 SS=E	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:	K 712		5/24/18

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K 712	Continued From page 11 Based on documentation review and staff interview the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills could result in injury or death in the event of an emergency. The deficiency affected three (3) of three (3) smoke compartments on the main floor, and the basement. The findings were: Documentation review on 05/03/18 at 12:30 PM revealed that the facility had performed fire drills once every quarter for every shift from October 2017 thru April 2018, but had no additional documentation for fire drills. Fire drills shall be conducted quarterly on each shift. Interview with the maintenance director at the time of the observation acknowledged the missing documentation, and indicated that he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.7.1.6	K 712	1. The facility will ensure that fire drills are conducted on a monthly basis and that drill times are staggered by shift so that in the span of a quarter all shifts will have had a fire drill conducted. All fire drills will be properly documented. 2. All residents are affected. Three (3) of three (3) smoke compartments on the main floor including basement affected. 3. Fire drill was conducted and properly documented on 5/23/18 at 1515. On 5/23/18 ED educated Maintenance Manager on policy and procedure requiring fire drills be conducted monthly and at staggered times to ensure all shifts have had a fire drill conducted within a quarter as well as how to properly document and record drills in accordance with state and federal regulation. 4. The facility will incorporate auditing of Fire Drill compliance into facility weekly preventive maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced	K 781		5/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**05/04/2018**

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

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K 781	Continued From page 12 by: Based on observation and staff interview the facility failed to maintain portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. Failure to limit portable space heaters to only the allowable areas could result in injury or death as it increases the risk of fire. The deficiency affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/03/18 at 11:21 AM revealed the social services office had a portable space heater located next to the desk. The office is located in a smoke compartment that contains resident sleeping rooms. Portable space heaters shall be prohibited in all health care occupancies unless such devices are used only in nonsleeping staff and employee areas. Interview with the maintenance director at the time of the observation acknowledged the portable space heater was located in a resident sleeping smoke compartment, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.7.8	K 781	1. The facility will ensure that there are no space heaters utilized in a smoke compartment where residents are living. 2. All residents are affected. One (1) of three (3) smoke compartments on the main floor affected. 3. The space heater in the Social Service Office was removed on 5/3/18. Further, on 5/4/18 an audit was conducted of the entire facility for any other space heaters and no further discrepancies were found. On 5/23/18 ED educated Maintenance Manager on the regulation that no smoke compartment in which a resident resides is allowed to have space heaters in use. 4. The facility will incorporate auditing of facility for space heaters into facility weekly preventive maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		5/24/18

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	535051	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**05/04/2018**

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K 920	Continued From page 13 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed 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 use power strips could result in injury or death due to an increased risk of electrocution or fire. The deficiency affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/03/18 at 11:35 AM revealed resident room 15 had an oxygen concentrator plugged into a power strip located within the patient care area. Interview with the maintenance director at the	K 920	1. The facility will ensure that any electrical equipment related to resident care is not plugged into a power strip but plugged directly into a wall mounted outlet. 2. All residents are affected. One (1) of three (3) smoke compartments on the main floor affected. 3. The oxygen concentrator in room #15 found to be plugged into a power strip was immediately plugged into the wall outlet on 5/3/18. Further, on 5/4/18 an audit was conducted of the entire facility to ensure that no electrical equipment related to resident care is plugged into a power strip and no further discrepancies were found. ED educated Maintenance Manager on	

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K 920	Continued From page 14 time of the observation acknowledged the deficiency, and indicated that he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920	5/23/18 on the regulation that mandates all electrical equipment related to resident care be plugged directly into a wall mounted outlet and not a power strip. 4. The facility will incorporate auditing of compliance for all electrical equipment related to resident care into facility weekly preventive maintenance program. Audit results will be brought to monthly QAPI Meeting. 5. The ED is responsible for compliance.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 05/03/2018. Based upon the findings of the survey team, it was determined that the facility was in compliance with all Emergency Preparedness requirements.	E 000		

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

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.