STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/27/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	**388 SOUTH US HWY 20** **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 3/27/2019. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) 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 V (000) construction with plan approval in 1973. The building is equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 37 certified Medicare and Medicaid beds with a census of 30 residents.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 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 result in injury or death in the event of an emergency. The deficiency affected one (1)	K 211	A) The obstruction was removed at the time of observation during the Life Safety Survey. The fabric STOP sign had been placed to help redirect a dementia resident that no longer resides at the facility. The sign was attached to a	4/12/19

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

Electronically Signed | 04/18/2019

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 211	Continued From page 1 of two (2) smoke compartments. The findings were: Observation on 03/27/19 at 10:29 AM revealed a fabric "STOP" sign installed in front of the exit door to the exterior at the end of the west resident wing. It is required that no furnishing or other objects shall obstruct access to an exit. Interview with the maintenance director and facility administrator at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Reference: 2012 NFPA 101 19.2.1, 7.1.10.2.1 .	K 211	breakaway alarm device that would still allow unimpeded egress from the facility. It had not previously been considered an impediment to egress. B) This obstruction was removed and such devices will no longer be allowed in egress paths or exits per NFPA 101. C) The daily inspection of egress paths and exits for obstructions has been added to the Daily Checklist completed by maintenance staff. This process was started 4/12/2019. D) The Director of Plant Operations and Maintenance Staff will ensure compliance daily and document results on the Daily Checklist.	
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 document 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 properly test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected two (2) of two (2)	K 345	A) Fire drill processes were only meeting the quarterly drill requirements and not meeting the requirement for testing alarm system operation on a monthly basis. In order to meet this requirement fire alarm activation has been added to the monthly maintenance checklist.	4/12/19

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K 345	Continued From page 2 smoke compartments. The findings were: Document review on 03/27/19 at 11:36 AM revealed that the facility was conducting quarterly fire drills on both shifts and activating the fire alarm system during these tests. Additional review revealed that the fire alarm was not being activated during months when fire drills were not performed. The fire alarm must be activated monthly to verify proper operation. Interview with the maintenance director and facility administrator at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Reference: 2010 NFPA 72 Table 14.4.5.24, Table 14.4.2.2.19	K 345	B) Maintenance personnel will ensure the fire alarm system is activated each month and document compliance on the Monthly maintenance checklist. C) This process was implemented 4/12/2019. D) The Director of Plant Operations and Maintenance Staff will ensure compliance each month and document results on the Monthly Checklist.	
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 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	K 920		5/31/19

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K 920	Continued From page 3 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 use power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to use power strips properly could result in injury or death in the event of an emergency. The deficiencies affected two (2) of two (2) smoke compartments. The findings were: Observation on 03/27/19 at 10:16 AM and throughout the survey revealed that in resident rooms 101, 102, 103, 105, and 110 power strips were within the patient care vicinity that were being used for non-patient care electrical equipment. The rooms did not have any patient care related electrical equipment in them. The power strips being used either had no obvious UL listing or had a UL listing that did not meet UL 1363. Resident rooms without patient care related electrical equipment must have UL 1363 listed power strips for use with non-patient care related equipment. Interview with the maintenance director and facility administrator at the time of the observation acknowledged the deficiency, and indicated they	K 920	A) Facility policy at the time of the survey was that power strips could be utilized in resident rooms for non-patient-care-related electrical equipment and that patient care equipment was to be plugged directly into a wall outlet. Power strips were being utilized for non-PCREE electrical items in rooms that did and did not have patient-care-related electrical equipment (PCREE). These power strips were often within the patient care vicinity and were not labeled as UL 1363. This will be remedied by revising the facility policy to remove power strips for non-PCREE items from the patient care vicinity as well as ensuring power strips for these items meet UL 1363. Facility policy will also be revised to ensure only power strips labeled UL 1363A or UL 60601-1 are utilized for PCREE. B) Maintenance staff will inventory rooms for PCREE and non-PCREE items. Where necessary only UL 1363A or UL 60601-1 labeled power strips will be allowed in the patient care vicinity and only PCREE will be plugged into those	

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K 920	Continued From page 4 were unaware of the requirement. Observation on 03/27/19 at 10:20 AM and throughout the survey revealed that in resident rooms 108 and 202 power strips were within the patient care vicinity that were being used for non-patient care electrical equipment. The rooms had patient care related electrical equipment in them that were plugged directly into wall outlets. The power strips being used either had no obvious UL listing or had a UL listing that did not meet UL 1363. Resident rooms with patient care equipment must have UL 1363 listed power strips for use with non-patient care related electrical equipment, and the power strips must be located outside the patient care vicinity. Interview with the maintenance director and facility administrator at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement.	K 920	power strips. Power strips supplying non-PCREE items will be located outside of the patient care vicinity and be labeled UL 1363. C) Compliance will be monitored by maintenance staff upon admission or relocation of residents as well as during monthly safety rounds. These rounds will be documented on the Monthly Checklist. D) The Director of Plant Operations and Maintenance Staff will be responsible for revising the power strip policy as well as ensuring and documenting compliance on the Monthly Checklist. These processes will be in place by 5/31/2019.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 03/27/2019. .	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [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 annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only.	E 015		4/26/19

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Electronically Signed | 04/18/2019

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E 015	Continued From page 1 The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide policies or procedures for subsistence needs for staff and patients. The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility did not have policies or procedures addressing subsistence needs for staff and patients when they evacuate or shelter in place. Interview with the facility administrator revealed that contracts were in place, or in process, for obtaining food, water, medical equipment, pharmaceutical supplies, and fuel for the emergency generator from outside vendors in the event of an emergency. However, they were unavailable at the time of the survey. .	E 015	This requirement will be met as evidenced by: A) The policies for addressing food, water, medical, pharmaceutical and fuel needs were drafted to an extent, but unavailable at the inspection. Specifically, subsistence needs and fuel needs were being addressed, but pharmaceuticals were not. These plans will be addressed and finalized to be incorporated into our emergency plan and policy. B) The food subsistence needs policies will be expedited though our policy and procedure guidelines and communicated to all affected staff. The emergency department will be combining all of these needs into a single policy. The policy will change and this facility will be fully compliant by 4/26/19. C) Compliance will be maintained	

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E 015	Continued From page 2	E 015	through an annual review by the Emergency Preparedness committee. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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 annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. 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 the role of the facility under a waiver.	E 026	This requirement will be met as evidenced by: A) The reference deficiency is that the ¿1135 Social Security Act requirement of	4/26/19

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E 026	Continued From page 3 The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility did not have policies and procedures on the role of the facility under a waiver declared by the Health and Human Services Secretary in accordance with section 1135 of Social Security Act. Interview with the facility administrator revealed he was unaware that this requirement was missing from the plan. .	E 026	operation of a facility under a waiver policy is not present. This policy appears to not exist at all. It will be written and incorporated as soon as it is completed. B) The deficient waiver policy will be expedited through our policy and procedure guidelines and communicated to all affected staff. The policy will be written and the facility will be fully compliant by 4/26/19. C) Compliance will be maintained through an annual review by the Emergency Preparedness committee. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(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 annually. 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 RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		4/26/19

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E 030	Continued From page 4 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 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: (1) Names and contact information for the	E 030		

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E 030	Continued From page 5 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 include all requirements in the Communications Plan. The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility had a "names and contacts" list that did not include entities providing services under arrangement. Interview with the facility administrator revealed he was unaware that this requirement was missing from the plan. .	E 030	This requirement will be met as evidenced by: A) The plan for communications was in place for the most part, but not in a cohesive document. The contacts for these entities were available, but dispersed in individual policies and binders. The numbers will be added to the communications plan and list. Some of the contacts necessary for this communication plan had not been identified yet. Specifically, the need for contact of pharmaceuticals. These will be added to the plan as well. B) The communications procedure will be remedied by emergency management and communicated to all affected staff. Contact with necessary parties have already been made as of 4/16/19. The plan will be addressed and this facility will be fully compliant by 4/26/19. C) Compliance will be maintained through an annual review by the Emergency Preparedness committee. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035		4/26/19

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E 035	Continued From page 6 [(c) The [LTC facility and ICF/IID] 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 annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. 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 sharing information from the emergency plan. The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility had no policy or procedure for sharing information with residents and their families or representatives in regards to the emergency plan. Interview with the facility administrator revealed he was unaware that this requirement was missing from the plan. .	E 035	This requirement will be met as evidenced by: A) The policy for addressing the sharing of information with the residents and their families was not in place. This policy will be written by emergency management to address this deficiency. B) The referenced deficient procedure regarding communication with our residents will be written and expedited though our policy and procedure guidelines. Once completed, it will be communicated to all affected staff and residents. The policy will change by 4/26/19 and this facility will be fully compliant. C) Compliance will be maintained through an annual review by the Emergency Preparedness committee. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d)	E 036		5/31/19

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	535019	A. BUILDING _____ B. WING _____	03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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E 036	Continued From page 7 (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036		

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E 036	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a training and testing program. The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility had no training and testing program. Interview with the facility administrator revealed implementation of quarterly training on the emergency preparedness had recently begun, and the facility was in the process of updating their on-boarding program to include emergency preparedness training. .	E 036	This requirement will be met as evidenced by: A) A training program was complete, but had not rolled out yet. The testing program was in effect in the form of drills conducted by the facility. The facility conducts quarterly fire drills. A more in-depth drill program will roll out upon implementation of the training program. The training program was set to roll out during the month of May and is on track to meet that target. The testing program will go into effect after training has met its goals. B) The referenced deficiency in training will be addressed within the next month. Upon completion of training and testing, this facility will be fully compliant. The training should be in full swing by 5/31/19 with testing to follow. C) Compliance will be maintained through an annual review by the Emergency Preparedness committee, and through the on-boarding process administered by Human Resources to new hires. Drills will become a common occurrence with and without warning. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The	E 039		4/19/19

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E 039	Continued From page 9 [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes 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. (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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency	E 039		

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E 039	Continued From page 10 plan. The [RNHCI and OPO] 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 and 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. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct exercises to test the emergency plan. The findings were: Document review of the Emergency Preparedness Plan on 03/27/19 at 10:45 AM revealed the facility had no records of conducting a full-scale exercise, nor any documentation of conducting a tabletop exercise within the last year. Interview with the facility administrator revealed that the facility had conducted a community based full-scale exercise within the last year, as well as a table top exercise, but he was unable to provide supporting documentation.	E 039	This requirement will be met as evidenced by: A) The County EMC conducted a tabletop exercise simulating a regional power outage on 01/09/19. SBH EMC and other emergency response representatives were in attendance. The exercise involved agencies from all over Big Horn County. This facility conducted a table top exercise at the quarterly Emergency Preparedness committee meeting simulating a critical staff shortage on 2/20/19. Nearly all leaders were present for the exercise, including the LTC leaders. The evidence of that was in the EMC records, but were not produced during the inspection. The full-scale Community based drill was conducted by the Big Horn County Emergency Management Coordinator in Greybull. They simulated a hazardous material explosion on the railway. The Emergency Management Coordinator for South Big	

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E 039	Continued From page 11	E 039	Horn Hospital, Sheriff□s Office, Fire, National Guard and other Emergency personal were in attendance. This event was not documented and was not available at the time of the inspection. B) The documentation deficiency will be remedied through documentation to an EMC event list which records the date, type and pertinent information for events like drills, training and meetings. This document was in place during the review, but not accessible to the inspector. This will also be remedied by placing that documentation in an easily accessible binder. C) Compliance will be maintained through an annual review by the Emergency Preparedness committee and regular updates by the EMC. D) The specific responsible party to ensure compliance will be the Emergency Management Coordinator.	