STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**04/06/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

(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 April 6, 2021. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on April 6, 2021. Requirements for Hospitals Section 42 CFR 482.41 (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 the National Fire Protection Association. The facility was a fully sprinklered, three-story building with a basement of a Type II (222), and Type II (111) construction built in 1966 and 1972. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 107 residents. .	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless	K 222		5/17/21

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

Electronically Signed | 05/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 2 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous doors in the facility. The findings were: Observation on 4/6/2021 at 2:32 PM at the doors leading into the courtyard by room 104 revealed that the doors exceeded thirty (30) pounds of force to open. Further observation found that the two doors had been duct taped down the middle to reduce outside air entering the facility. Additional observations found the egress doors by room 110 at the other end of the hallway also exceeding thirty (30) pounds of force to open, with duct tape obstructing the door movement. Interview with the maintenance manager at the time of observation acknowledged the deficiency,	K 222	K222 1. Duct tape removed at the time of deficient practice for the doors leading into the courtyard by room 104 and the egress doors by room 110. 2. The Maintenance Director visualized facility egress doors for duct tape. 3. The Executive Director provided education to the Maintenance Director regarding doors in a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or a key from the egress side unless using a special locking arrangement. 4. The Maintenance Director or designee will visualize egress doors bi-weekly for 90 days that is shall not be equipped with duct tape, a latch or a lock. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until	

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K 222	Continued From page 3 and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.2.2.2.1, 7.2.1.4.5 .	K 222	substantial compliance has been achieved or sustained as directed by the committee.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous doors with self-closures in the facility. The findings were:	K 223	K223 1. Cart by room 116 was removed at the time of the deficient practice. 2. The Maintenance Director or designee provided education to staff regarding maintaining doors with self-closing devices. 3. The Maintenance Director or designee provided education to staff regarding maintaining doors with	5/17/21

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K 223	Continued From page 4 Observation on 4/6/2021 at 2:39 PM at the doors by room 116 and the nurses station revealed a cart placed in front of the southeast door. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.2.2.2.1, 7.2.1.4.5 .	K 223	self-closing devices. 4. The Maintenance Director or designee will visualize self-closing doors weekly for 90 days to validate doors are kept in the closed position. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of several stairwells in the facility. The findings were: Observation on 4/6/2021 at 3:27 PM in the stairwell by the basement maintenance area	K 225	K225 1. Combustibles were removed at the time of the deficient practice 2. The Maintenance director completed an audit of stairwells to validate the stairwells are free of stored combustibles. 3. The Maintenance Director or designee provided education to staff regarding maintaining stairwells be free of stored combustibles. 4. The Maintenance Director or	5/17/21

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K 225	Continued From page 5 revealed combustibles stored underneath the stairs at the bottom. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.2.2.3; 7.2.2.1.1; 7.2.2.5.3; 7.2.2.5.3.1; 7.1.3.2.1 (9)(c)(ii); 7.1.3.2.3 .	K 225	designee will visualize stairwells bi-weekly for 90 days to validate the stairwells are free of stored combustibles. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting as required could result in injury or death during an emergency. The deficiency affected one (1) of four (4) battery back-up lights in the facility. The findings were: Observation on 4/6/2021 at 1:59 PM on the southwest wall of the rehab area on the first floor revealed that the battery powered light failed when put into test mode. In an emergency, failure of the battery-powered lighting could delay or prevent egress from the space.	K 291	K291 1. Battery powered light was validated to be operable at the time of the deficient practice. 2. The Maintenance director or designee will complete an audit of Battery powered lights to validate operability. 3. The Executive Director or designee will provide education to the Maintenance staff regarding battery powered lights to validate operability. 4. The Maintenance Director or designee will audit battery powered lights to validate operability weekly for 90 days. The Maintenance Director or designee will report the tracking and trending of the	5/17/21

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K 291	Continued From page 6 Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.9.1, 7.9 .	K 291	audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 293 SS=D	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 exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death. The deficiency affected one (1) corridor out of numerous corridors in the facility. The findings were: Observation on 4/6/2021 at 3:28 PM in the basement corridor by the maintenance shop looking towards the elevators, revealed that no exit sign could be observed in the corridor. Interview with the facility maintenance manager at	K 293	K293 1. Basement corridor exit sign installed. 2. The Maintenance Director or designee completed an audit of exit corridors to validate exit signs could be observed. 3. The Executive Director or designee reviewed with the Maintenance Director to validate that the annual exit sign inspection is completed annually. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or	5/17/21

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K 293	Continued From page 7 the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.1.1, 7.10.1.5.1 .	K 293	until substantial compliance has been achieved or sustained as directed by the committee.	
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)	K 321		5/17/21

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K 321	Continued From page 8 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 maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 4/6/2021 at 1:35 PM in MDS office bathroom revealed an excessive amount of paper records in a non-rated room. The room was sprinkled, but doors were not self-closing. Further observation revealed that the employee lounge contained an excessive amount of combustible storage. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2 .	K 321	K321 1. The paper records in the MDS office were removed. The combustible storage in the employee lounge was removed. 2. The Maintenance Director or designee will complete an audit to validate office bathrooms are free of excessive combustible storage. 3. The Maintenance Director or designee will educate office staff to validate their offices are free of excessive combustible storage. 4. The Maintenance Director or designee will audit office bathrooms the validate it is free of excessive combustible storage. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by	K 351		5/17/21

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K 351	Continued From page 9 construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency one (1) of numerous rooms. The findings were: Observation on 4/6/2021 at 10:09 AM in kitchen pantry revealed an air duct obstructing the sprinkler head. Interview with the maintenance director at the time of observations acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 351	K351 1. An additional sprinkler head will be installed in the kitchen panty to allow for adequate sprinkler coverage. 2. The Maintenance Director or designee visualized the facility for air ducts obstructing the sprinkler system. 3. The Maintenance Director or designee will add the newly installed sprinkler head to his weekly Preventative Maintenance checks. 4. The Maintenance Director or designee will report the tracking and trending of the review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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K 351	Continued From page 10 REF: 2010 NFPA 13, Sections: 8.6.5 .	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide access to fire extinguishers in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers and the 2012 NFPA 101, Life Safety Code. Failure to provide access to a fire extinguisher as required may lead to injury or death during an emergency. The deficiencies affected one (1) of numerous fire extinguishers in the facility. The findings were: Observation on 4/6/2021 at 10:04 AM in the Kitchen found the K-type fire extinguisher obstructed from access, due to a cart placed in front of it. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 9.7.4.1 2010 NFPA 10: Sections 6.1.3.1; 6.1.3.3.1 .	K 355	K355 1. Cart in front of Kitchen fire extinguisher was removed at the time of the deficient practice. 2. The Maintenance Director or designee provided education to kitchen staff regarding access to fire extinguishers. 3. The Maintenance Director or designee will educate staff regarding access to fire extinguishers. 4. The Maintenance Director or designee will randomly audit fire extinguishers to validate it is accessible. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	5/17/21

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GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		5/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**04/06/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 363	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain corridor doors as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 4/6/2021 at 1:57 PM at the double doors going into the rehab space on the first floor, by the family room, revealed the left door with a closure that failed to fully latch when released from full open at a dead stop. Further observations found that the janitors closet across from room 106 also failed to latch. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.6.3.5 .	K 363	K363 1. Double doors on 1st floor and the janitors closet doors' tension was adjusted to latch. 2. The Maintenance Director or designee will audit self-closing doors to validate it fully latches. 3. The Maintenance Director or designee will educate staff regarding self-closing doors to validate it fully latches. 4. The Maintenance Director or designee will audit self-closing doors weekly to validate it fully latches. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
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 installations can continue in service provided no hazard to life.	K 511		5/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**04/06/2021**

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GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 511	Continued From page 13 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 the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected four (4) of numerous rooms in the facility. The findings were: Observation on 4/6/2021 at 9:51 AM in the secured unit's nurse's station bathroom revealed a duplex receptacle within six (6) feet of the sink, which was not protected by a ground fault circuit interrupter. Further observation found the same issue with the bathroom at the end of C wing on the second floor, the rehab office bathroom, and the business office bathroom. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B) .	K 511	K511 1. Ground Fault Circuit Interrupter was installed in the secured unit nurses station bathroom, second floor C hall restroom, rehab office bathroom and the business office bathroom. 2. The Maintenance Director or designee will complete an audit of non-resident bathrooms to validate a ground fault circuit interrupter is installed. 3. The Maintenance Director or designee will add the newly installed GFCI to his annual Preventative Maintenance checks. 4. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens	K 920		5/17/21

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K 920	Continued From page 14 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 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 maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected four (4) of numerous rooms in the facility. The findings were: Observation on 4/6/2021 at 10:50 AM in room 203 revealed an extension cord plugged into a	K 920	K920 1. Power strip daisy chains in room 203, central supply office, social services office, and the rehab office were removed at the time of the deficient practice. 2. The Maintenance Director or designee will complete an audit of offices and resident rooms to validate power strip daisy chains are removed. 3. The Maintenance Director or Designee will educate staff regarding	

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K 920	Continued From page 15 power strip creating a daisy chain. Additional observations found daisy chained power strips in the Central Supply office, the Social Services Office, and the Rehab office Interview with the maintenance director at time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2011 NFPA 70, Section 400.8	K 920	approved power strips to validate power strips are not daisy chained. 5. The Maintenance Director or designee will randomly audit 30 resident rooms and 1 office a week to validate power strips are not daisy chained. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	