STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING **01** B. WING _____	**08/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	**707 SHERIDAN AVENUE** **CODY, WY 82414**

(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 08/26/2021. Based on the finding of the survey, it was determined that 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 August 25th, 2021 through August 26th, 2021. Requirements for Long Term Nursing Homes Section 42 CFR 483.700(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, two-story building with a basement of Type II (111) construction built in 1982 and renovated in 1992 with an addition in 2010. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 94 certified Medicare and Medicaid beds with a census of 59. .	K 000		
K 222 SS=E	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 using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		9/10/21

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

Electronically Signed | 09/20/2021

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K 222	Continued From page 1 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 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

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K 222	Continued From page 2 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 means of egress doors in accordance with the 2012 NFPA 101 Life Safety Code. Failure to maintain means of egress doors could result in injury or death in the event of an emergency. The deficiencies affected two (2) of several exit doors on the main and second floor. The findings were: Observation on 08/25/21 at 11:35 AM revealed an exit stairway door located on the main floor in the memory care area. The door was equipped with a delayed-egress system, which was active, but the door did not have the required signage for a delayed-egress door. A second door was discovered to have an active delayed-egress system without the required signage at the second floor, north exit stairway. All doors with a delayed-egress system shall have a visible sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". Interview with the facilities director at the time of	K 222	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. Appropriate signage was installed. Administrator or designee will audit weekly for the next 60 days to verify continued compliance with signage. 4. Administrator or designee will report results of audits to QAPI monthly for the next 60 days. Additional audits and/or interventions will be instituted if needed to ensure ongoing compliance.	

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K 222	Continued From page 3 the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.2.2.4; 7.2.1.6.1 .	K 222		
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress corridors in accordance with the 2012 NFPA 101 Life Safety Code. Failure to maintain means of egress corridors could result in injury or death in the event of an emergency. The deficiencies affected two (2) smoke compartments on the main floor and two (2) smoke compartments on the second floor. The findings were: Observation on 08/25/21 starting at 11:20 AM, and throughout the survey, revealed that the corridors located in patient sleeping areas were being used to store patient lifts and wheelchairs	K 232	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. lifts, equipment and moveable furniture referred to were moved to designated storage areas. Staff were inserviced on ensuring means of egress is clear. Administrator or designee will audit weekly for the next 60 days to verify continued compliance. 4. Administrator or designee will report results of audits to QAPI monthly for the next 60 days. Additional audits and/or interventions will be instituted if needed to ensure ongoing compliance.	9/25/21

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K 232	Continued From page 4 as well as some non-secured furniture. Interview with the facility manager at the time of the observation revealed that a means of relocating wheeled equipment from the corridor during an emergency was not part of their fire safety plan. Furniture is acceptable in the corridor, but must satisfy all conditions of the 2012 NFPA 101 including being secured to the floor. Interview with the facilities director at the time of the observation acknowledged the deficiency, and indicated that they were not aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.2.3.4 .	K 232		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by 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	K 351		10/1/21

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K 351	Continued From page 5 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 install fire sprinkler systems in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems . Failure to properly install the fire sprinkler system 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: Observation on 08/25/21 at 10:28 AM revealed that the personal care room had a closet behind a stained glass window that was not protected by a sprinkler. Sprinklers shall be installed throughout the premise including in concealed spaces of combustible construction with potential storage of combustibles. Interview with the facilities director at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 13 8.1.1, 8.15.1.1 .	K 351	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. Sprinkler vendor has been contacted and installation of new sprinkler head(s) will be completed by 10/1. Facilities Director or designee will coordinate installation with vendor to ensure compliance. 4. Facilities Director or designee will report progress of installation to QAPI until completed.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		10/25/21

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K 372	Continued From page 6 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoke barriers could result in injury or death in the event of a fire. The deficiencies affected one (1) smoke barrier of two (2) on the main floor. The findings were: Observation on 08/25/21 at 1:55 PM revealed the smoke barrier that separates the main entrance area from the dining area and activities area had multiple unprotected plumbing, conduit, and structural penetrations. As well, the smoke barrier had two sets of glass double doors. As no labeling was observed on the doors, it could not be established that the doors were of a construction type that would resist fire for a minimum of 20 minutes, nor could it be established that the doors contained fire-rated glazing. Smoke barriers shall be constructed to resist the movement of smoke, and shall be continuous to the floor or roof above, including	K 372	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. A work order and plan has been initiated to rebuild the wall. Investigation has started on fire rating of glass doors to determine the rating and/or replacement as part of the project. Facilities Director or designee will coordinate repair project activities until completed. Anticipated completion will be within 60 days. 4. Facilities Director or designee will report progress of repairs to QAPI monthly for the next 60 days.	

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K 372	Continued From page 7 through concealed spaces. Doors in smoke compartment barriers shall be constructed to resist fire for a minimum of 20 minutes, and be provided with fire-rated or wired glass as applicable Interview with the facilities director at the time of the observation acknowledged the deficiency, and revealed they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.3.7.3, 19.3.7.6, 8.5.6 .	K 372		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		10/1/21

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K 923	Continued From page 8 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stored oxygen in accordance with the 2012 NFPA 99 Health Care Facilities Code. Failure to maintain stored oxygen could result in injury or death in the event of a fire. The deficiency affected one (1) of one (1) oxygen storage room. The findings were: Observation on 08/25/21 at 10:40 AM revealed that the oxygen storage room on the main floor had an interior and exterior door. Neither door had the required precautionary sign installed. A readable sign shall be displayed on each door of the oxygen storage room and shall read "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Interview with the facilities director at the time of the observation acknowledged the deficiency, and	K 923	1. No residents were identified as being affected. 2. All residents have the potential to be affected. 3. Correct signs were ordered and will arrive by 10/1 for posting. 4. Facilities Director or designee will report progress on signage to QAPI until complete.	

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K 923	Continued From page 9 indicated that they were not aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99 11.3.4	K 923		