

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535034		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021	
NAME OF PROVIDER OR SUPPLIER WESTWARD HEIGHTS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 150 CARING WAY LANDER, WY 82520			
(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 10/13/2021.			E 000			
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.			E 022			11/19/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/04/2021

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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E 022	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a policy for sheltering in place. The findings were: Review of the Emergency Preparedness Plan (EPP) on 10/13/21 at 2:00 PM revealed that a policy specifically addressing a means to shelter in place for patients, staff, and volunteers was not provided. Interview with the Director of Nursing acknowledged the deficiency, and revealed they were unaware that this requirement was missing from the plan. .	E 022	Correct deficiency to individual: Shelter in Place policy has been placed in the Disaster Plan books as part of the complete disaster plan. Protect Residents from similar situations: The policy is in place and the manual has been updated with the Shelter in Place. The Shelter in Place Policy will be reviewed with all team members at the Safety Fair on November 18. Measures/Systemic Changes: Maintenance Supervisor or designee will check that the Shelter in Place policy is included during the annual Disaster Plan Review and sign off. Monitor permanent solution: Maintenance Supervisor will check that the plan is in the Disaster Plan, and that training is complete and report at the next Safety meeting.		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]	E 037			11/19/21

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E 037	Continued From page 2 (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and	E 037			

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E 037	Continued From page 3 procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE	E 037			

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E 037	Continued From page 4 must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF	E 037			

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E 037	Continued From page 5 must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	E 037			
			Correct Deficiency to individual: The		

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E 037	Continued From page 6 the facility failed to provide emergency preparedness training as required. The findings were: Review of the Emergency Preparedness Plan (EPP) on 10/13/21 at 2:00 PM revealed that the facility was conducting initial training on the emergency preparedness policies and procedures to new staff, but were not providing additional annual training to all staff. Interview with the Director of Nursing revealed that annual training of the EPP is conducted in November, but was cancelled last year due to COVID and not rescheduled. All staff shall be provided emergency preparedness training at least annually. Interview with the Director of Nursing acknowledged the deficiency, and revealed they were aware of this requirement. .	E 037	facility has scheduled annual training for emergency program preparedness for November 18th. Protect Residents from similar situations: The facility will schedule an annual facility wide emergency program training each November. Measures systemic changes to prevent reoccurrence: Administrator educated Maintenance Supervisor on the requirement of annual training on 10/28/21. Administrator will schedule the annual emergency program preparedness training each November to meet this requirement. Monitor Permanent Solutions: The Emergency Preparedness Training will be completed in November and the attendance will be reported at the next month's safety meeting by the Administrator.		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039		11/19/21	

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E 039	Continued From page 7 (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the	E 039			

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E 039	Continued From page 8 patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039			

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E 039	Continued From page 9 accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an	E 039			

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E 039	Continued From page 10 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from	E 039			

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E 039	Continued From page 11 engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the	E 039			

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E 039	Continued From page 12 LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039			

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E 039	Continued From page 13 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039			

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E 039	Continued From page 14 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]:	E 039			

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E 039	Continued From page 15 (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI 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 response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide emergency preparedness testing as required. The findings were: Review of the Emergency Preparedness Plan (EPP) on 10/13/21 at 2:00 PM revealed that the facility had not engaged in a full-scale exercise nor a tabletop exercise in the last twelve (12) months. Under the COVID-19 emergency the facility is exempt from engaging in a full-scale exercise for the year, however, a second full-scale exercise or tabletop exercise must still be conducted. Interview with the Director of Nursing acknowledged the deficiency, and revealed that it was their understanding that under the COVID-19 emergency the facility was exempted from all testing. .	E 039	Correct Deficiency to individual: The facility has scheduled a table top disaster exercise for 11/11/21. Protect Residents from similar situations: The facility will schedule an annual facility wide disaster drill or compete in the coalition drill to maintain compliance with this requirement. Measures systemic changes to prevent reoccurrence: Administrator educated Maintenance Supervisor on the requirement of annual training on 10/28/21. Maintenance Supervisor will put this requirement into TELS system for annual reminder for November. Monitor Permanent Solutions: Disaster table top exercise is scheduled for 11/11/21 and the results will reported to the next Safety Committee meeting. Annual scheduling of disaster drill will be		

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E 039	Continued From page 16	E 039	added to November on the TELS schedule.		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 10/13/2021. 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, New Health Care and Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, one story building of Type V (111) construction built in 1978 with two additions built in 1996, and an addition of Type II (000) construction built in 2020. The two construction types were separated by 2-hour fire barriers. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 66 certified Medicare and Medicaid beds with a census of 50 residents.				
K 100 SS=E	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This REQUIREMENT is not met as evidenced	K 100			

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K 100	Continued From page 17 by: Based on observation and staff interview, the facility failed to maintain fire-resistive construction in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire-resistive construction could result in injury or death in the event of an emergency. The deficiency affected one (1) of three (3) 2-hour fire barriers. The findings were: Observation on 10/13/21 at 1:04 PM revealed that the 2-hour fire barrier separating the existing nursing home from the new addition had an unprotected penetration above the ceiling. Observation of the north-west 2-hour fire barrier revealed a 3 inch CPVC pipe that was used to run an electrical wire through the barrier. The CPVC pipe was not properly sealed to resist the spread of fire and smoke from one side of the fire barrier to the other. Fire-resistive construction must be continuously maintained. Interview with the facility director at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 18.1.1.1.3, 4.6.12.1	K 100	Correct deficiency: The Maintenance Supervisor fixed the unprotected penetration in the fire barrier on 10/29/21. Audit will be done monthly for three months above the ceiling to ensure there are not unprotected penetrations. If unprotected penetrations are found, they will be corrected immediately. Maintenance Supervisor will report audit to monthly Safety Meeting.		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		11/19/21	

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K 321	Continued From page 18 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 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in injury or death in the event of a fire. The deficiency affected one (1) of five (5) smoke compartments. The findings were:	K 321	The automatic door closer was put on the door on 10/29/21 by the Maintenance Supervisor. Education was provided to the Maintenance Supervisor on this requirement on 10/29/21 by the Administrator. Maintenance Supervisor will ensure that door closers are maintained on storage rooms larger than 50 square feet used to store combustible materials. Audit of all storage rooms will		

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K 321	Continued From page 19 Observation on 10/13/21 at 11:05 AM revealed the storage room located in the main dining room of the existing building was being used to store large quantities of combustible materials. The storage room was approximately 64 s.f. in size, and it was observed that an automatic door closer was installed at one time, but had been removed. Storage rooms larger than 50 s.f. used to store combustible materials shall be equipped with a self-closing or automatic-closing device. Interview with the facility manager at the time of the observation acknowledged the deficiency. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.3	K 321	be completed and reported to the next Safety Meeting. The Maintenance Supervisor will report this correction at the next monthly Safety Meeting.		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.	K 753		11/19/21	

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K 753	Continued From page 20 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect wall decorations in accordance with the 2012 NFPA 101 Life Safety Code. Failure to properly protect wall decorations could result in injury or death in the event of a fire. The deficiency affected one (1) of several resident rooms. The findings were: Observation on 10/13/21 at 11:56 AM revealed resident room "Suite 211" had three (3) fabric flags hung on the wall. The draperies were approximately 25 sq.ft. each in area and were placed next to each other on the same wall of the room. There was no indication that the flags were flame-retardant or treated with fire-retardant coating. Interview with the facility manager revealed that he did not believe any sort of flame retardant spray had been applied. Interview with the facility manager at the time of the observation acknowledged the deficiency. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.7.5.6	K 753	Correct deficiency to individual: Suite 211 there will be flame retardant applied to the 3 fabric flags that are hanging on the wall. They will be dated when the flame retardant is applied. Maintenance Supervisor will do an audit of the walls in rooms to ensure that fabrics hanging on the walls are treated with flame retardant. The results of the audit will be reported at the next monthly safety meeting. During monthly building rounds, the maintenance supervisor will look for any new fabric wall coverings that need to have flame retardant applied. Results of rounds will be reported at monthly safety meeting for 3 months.		
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	K 920			11/19/21

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K 920	Continued From page 21 used for components of movable patient-care-related electrical equipment (PCREE) assemblies 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 utilize power strips could result in injury or death in the event of electrical or equipment failure. The deficiency affected two (2) of five (5) smoke compartments. The findings were: Observation on 10/13/21 starting at 11:50 AM, and throughout the survey, revealed Patient Care Related Electrical Equipment (PCREE) plugged into power strips. Observation of resident rooms 214, 218, and 110 revealed oxygen concentrators in the the room with power strips located in the	K 920	Maintenance Supervisor moved all of the power strips out of the patient care area in rooms 214, 218, 110. Maintenance Supervisor was educated on the patient care area and not using power cords with there is patient care equipment present. Staff will be educated at the next all team meeting about this requirement. Maintenance Supervisor or designee will audit all resident rooms and relocate any power cords out of the patient care area. This audit will be done for three months and the results will be reported at the monthly safety meeting.		

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K 920	Continued From page 22 patient care area. Power strips shall not be located in the patient care area when PCREE is present. Interview with the facility manager at the time of the observation acknowledged the deficiency. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920			