

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

PRINTED: 12/02/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04 B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2021
NAME OF PROVIDER OR SUPPLIER GREEN HOUSE LIVING FOR SHERIDAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801		
(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 October 28, 2021.	E 000			
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004			12/28/21

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

TITLE

(X6) DATE

Electronically Signed

11/19/2021

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 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide an emergency preparedness plan that has been reviewed and updated annually. The findings were: Review of the Emergency Preparedness Plan (EPP) on 10/28/21 at 2:00 PM revealed the EPP was not being reviewed and updated on an annual bases. Review of the EPP revealed that the last update, according to the cover page and and subsequent signature pages, was October, 2019. Interview with the administrator at the time of exit acknowledged the deficiency.	E 004	E004 Maintenance Director will review and update the EPP including cover page and signature page on or before 12/28/2021. The EPP will be reviewed/updated yearly and as needed by the Maintenance Director. EPP items will be included in annual training and reviewed at the safety committee meeting when applicable.		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2),	E 018			12/28/21

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E 018	Continued From page 2 §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(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:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which	E 018			

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E 018	Continued From page 3 includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide an acceptable procedure for tracking of staff and patients.	E 018	E0018 EPP will be updated to include tracking of		

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E 018	Continued From page 4 The findings were: Review of the Emergency Preparedness Plan (EPP) on 10/28/21 at 2:00 PM revealed that a procedure for tracking of patients was provided. However, it did not include a means to track the location of on-duty staff. A system to track the location of staff and patients during an emergency shall be provided. Interview with the administrator at the time of exit acknowledged the deficiency.	E 018	on-duty staff on or before 12/28/2021 by Maintenance Director. Plan will be reviewed annually and as needed by Maintenance Director and at Safety Committee Meeting if applicable.		
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]: (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	E 039		12/28/21	

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E 039	Continued From page 5 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 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	E 039			

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E 039	Continued From page 6 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 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:	E 039			

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E 039	Continued From page 7 (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 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	E 039			

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E 039	Continued From page 8 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 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	E 039			

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E 039	Continued From page 9 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 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	E 039			

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E 039	Continued From page 10 (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 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	E 039			

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E 039	Continued From page 11 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: (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	E 039			

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E 039	Continued From page 12 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 [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (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.	E 039			

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E 039	Continued From page 13 (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 10/28/21 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 administrator at the time of exit acknowledged the deficiency.	E 039	E039: Maintenance director will have an emergency/disaster tabletop exercise with staff on or before 12/28/2021. Maintenance director will also join the local emergency training group to get training in full scale and tabletop exercises to share with staff at their next training session. Tabletop or full scale exercise will be conducted annually by Maintenance Director as part of the Safety Committee Meeting requirements. Education regarding emergency/disaster planning will continue to be provided annual to all staff by the Educator or designee.		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 28, 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, Existing Health Care, of the National Fire Protection Association.	K 000			

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K 000	Continued From page 14 The facility was a fully sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 11.	K 000			
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 28, 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, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 6. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements.	K 000			
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 28, 2021.	K 000			

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K 000	Continued From page 15 Requirements for Long Term Care Facilities Section 42 CFR 483.70(a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 10.	K 000			
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 28, 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, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 12.	K 000			
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920			11/19/21

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K 920	Continued From page 16 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) 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 one (1) of twelve (12) resident rooms. The findings were: Observation on 10/28/21 at 11:40 AM revealed resident room "1" with patient care related	K 920	K920: Maintenance department has removed all power strips from all rooms effective immediately. Maintenance Director to inspect rooms monthly and as needed to insure compliance. Education to provided to staff, elders, and family members regarding power strips upon admissions and as needed by the Maintenance Director or designee.		

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K 920	Continued From page 17 electrical equipment (PCREE) plugged into a power strip. Observation of the resident room revealed an oxygen concentrator plugged directly into a power strip. 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 administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Section 10.2.3.6, CMS S&C: 14-46-LSC	K 920			
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable 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	K 920		11/19/21	

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K 920	Continued From page 18 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 twelve (12) resident rooms. The findings were: Observation on 10/28/21 at 12:04 PM and 12:15 PM revealed resident rooms "403" and "404", respectively, with patient care related electrical equipment (PCREE) and power strips located in the patient care vicinity. Observation of the resident rooms revealed oxygen concentrators and cpap machines with power strips located in the area which could result in the PCREE being plugged into the power strips. 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 administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Section 10.2.3.6, CMS S&C: 14-46-LSC	K 920	K920: Maintenance department has removed all power strips from all rooms effective immediately. Maintenance Director to inspect rooms monthly and as needed to ensure compliance. Education to provide to staff, elders, and family members regarding power strips upon admissions and as needed by the Maintenance Director or designee.		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923			11/19/21

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K 923	Continued From page 19 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 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:	K 923			

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K 923	Continued From page 20 Based on observation and staff interview, the facility failed to store oxygen gas in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly store oxygen gas could result in injury or death in the event of a fire. The deficiency affected one (1) of one (1) oxygen storage rooms in the facility. The findings were: Observation on 10/28/21 at 12:47 PM revealed combustible storage located in the oxygen storage room. Observation of the oxygen storage room revealed that approximately 600 cubic feet of oxygen was being stored. The room was also being used to store a limited amount of combustible materials and equipment. Storage of oxygen gas greater than 300 cubic feet shall be separated from combustible materials by a minimum distance of 5 feet. Interview with the facility manager at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99 11.3.2.3	K 923	K923: Maintenance department removed all combustible items from the oxygen storage areas. Only oxygen bottles will be stored in the oxygen storage area. Maintenance Director to monitor storage areas weekly and as needed to ensure compliance. Education to be added to new-staff education, as needed and annually by Educator or designee regarding oxygen storage.		