STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING **01** B. WING _____	**11/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE** **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 November 24, 2021. Based on the findings 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 November 24, 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 sprinklered, single story building of Type V(111) construction built in 1962 and 1988. The building was equipped with a supervised, automatic dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 75.	K 000		
K 363 SS=E	. 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	K 363		12/13/21

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

Electronically Signed | 12/13/2021

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K 363	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect corridor doors could result in injury or death in the event of a fire.	K 363	K363 Correction: Lock on door in Therapy was missing and replaced on 11/30/2021. This was an	

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K 363	Continued From page 2 The deficiencies affected two (2) of five (5) smoke compartments. The findings were: (1) Observation on 11/24/21 at 1:26 PM at the double doors located in the physical therapy gym revealed that the door latching hardward had been removed. Additional observation revealed that one of the doors was designed to latch to the door frame and then the other door would latch to the first door using standard door latching hardware. The hardware was removed so the door would no longer latch to the door frame and thus would swing freely unless latched to the other door. Doors protecting corridor openings shall be self-latching and be provided with positive latching hardware. Interview with the administrator at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.6.3.5 (2) Observation on 11/24/21 at 12:09 PM in the IT room revealed that a dead-bolt lock had been removed from the door, which resulted in an approximate 1 inch hole in the door that was not sealed. Doors protecting corridor openings shall be constructed to resist the passage of smoke. Interview with the administrator at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency.	K 363	isolated incident with a missing lock. The door on the IT room had a missing deadbolt that was replaced on 11/30/2021. These were immediately fixed and issue has been resolved. Identification: This allowed residents access to a locked area and also could allow fire to blow through an enclosed space. This could allow residents in an unsafe area when not monitored by other staff. With the hole in the door, it could be a fire hazard creating air flow into an area that needs to be closed off. Audits will be completed on facility doors with locks and deadbolts preventing access for residents. This will be done weekly for 6 weeks and then monthly after that. Audits will be completed by Maintenance Team with results reported to Maintenance Director for keeping results. Systemic: Life Safety Team has been educated on 11/30/21 about importance of always checking locked doors. Therapy was also educated at the same time about safety of locking double doors. Therapy will check double doors daily to ensure slide bolt is engaged. Life Safety team will monitor doors locked to residents and report or fix issues immediately. Monitoring:	

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K 363	Continued From page 3 Reference: 2012 NFPA 101 19.3.6.3.1 .	K 363	Maintenance team will complete audits as discussed in previous paragraph. Audits will be discussed in Monthly QAPI meeting for 3 months and continue thereafter.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier 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 deficiency affected one (1) smoke barrier of five (5) in the facility. The findings were: Observation on 11/24/21 at 2:00 PM of the smoke barrier that separates the main entrance area from the resident 500 wing revealed that it was not sealed from floor to roof deck. Observation of	K 372	K372 Correction: We moved duct work and closed barrier door on 11/30/2021. We were able to reestablish the smoke barrier with the moving of the duct work and then closing smoke barrier door. Identification: The potential to affect several residents was a good risk. By allowing smoke to pass through a barrier, it can carry through the facility at a high rate of speed	12/13/21

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K 372	Continued From page 4 the smoke barrier above the ceiling revealed that a plastic duct had been run through the access panel resulting in the access panel being permanently open. Smoke barriers shall be constructed to resist the movement of smoke, and shall be continuous to the floor or roof above, including through concealed spaces. As well, where a smoke barrier is penetrated by a duct a smoke damper is to be installed. Interview with the administrator at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.3.7.3, 8.5.6, 8.5.5.2 .	K 372	causing concerns and issues with residents. This was the single barrier that was open and has been remedied thus eliminating potential for harm to several residents in case of a fire. We will audit smoke barriers weekly for 6 weeks and then audit monthly after that. This will take effect on 12/22/2021 and will continue going forward. Audits will be completed by Maintenance team with results being kept by Director. Systemic: Education has been provided to Maintenance team and Administrator about the locations of the barriers and how to access them. Education was provided by Maintenance Director on 11/30/2021. We will audit them and ensure that they remain closed even after maintenance has been performed in those areas. Audits will be conducted by the Maintenance team as discussed previously. This will ensure that we remain in compliance on the Smoke Barriers being enforced. Monitoring: Maintenance Director will present Audits at the next 3 QAPI Meetings and discuss any findings to the team.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and	K 920		12/13/21

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K 920	Continued From page 5 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 utilize power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to utilize power strips as required could result in injury or death in the event of electrical or equipment failure. The deficiency affected four (4) of multiple resident rooms. The findings were: Observation on 11/24/21 starting at 11:45AM in resident rooms 510, 404, 415, and 424 revealed patient care related electrical equipment (PCREE) plugged into power strips. Additional	K 920	K920 Correction: All power strips have been relocated in rooms from areas near medical equipment. This was completed on 11/30/2021 in rooms 510,404,415, and 424. Rooms are now free from an medical equipment plugged into or near a power strip. Identification: This has the potential for medical equipment to malfunction or to overload	

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K 920	Continued From page 6 observation of the resident rooms revealed oxygen concentrators, CPAP machines, or both plugged directly into power strips. Power strips shall not be located in the patient care area when PCREE is present. Interview with the administrator at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920	the power strip which could result in a fire. By removing them from the area, it allows the medical devices to be used correctly in the power outlet provided. This was isolated to only a few rooms, but could be widely abused if not addressed. Residents would bring in more power strips and use them to plug in other medical devices. Rooms with Power Strips will be audited once a week for 6 weeks and then monthly thereafter. This will start to take effect for us to be in compliance on 12/22/2021. Audits will be completed by Maintenance Team going forward. Systemic: Education has been provided to Maintenance team by the Director about importance of keeping medical devices away from power strips. This was done on 11/30/2021. When a power strip is needed, it will be provided by Maintenance Staff and they will set it up with the resident. They will educate the resident about how and where to use it. This will allow staff to maintain a safe environment for the residents. Audits will be completed by Maintenance as previously stated. Monitoring: Director will report to QAPI each month for the next 3 months on the audits. This	

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K 920	Continued From page 7	K 920	will ensure compliance and help to maintain a safe living environment.	