STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	**12/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR** **CASPER, WY 82601**

(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 December 16, 2021. .	E 000		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact	E 031		1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/14/2022

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E 031	Continued From page 1 information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to develop and maintain the emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. The findings were: Document review on 12/16/2021 at 10:30 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: Federal and State emergency preparedness staff, The State Licensing and Certification Agency, and the Office of the State Long-Term Care Ombudsman. Interview with the maintenance director at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. .	E 031	On or before 1/14/2022 Maintenance Director will correct the manual to include contact information The Maintenance Director was educated on this requirement. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	
K 000	INITIAL COMMENTS	K 000		

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K 000	Continued From page 2 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on December 15, 2021 through December 16, 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 with plan approval in 1967 and 1973. The building was equipped with a supervised wet sprinkler system with anti-freeze branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 86 residents. .	K 000		
K 222 SS=F	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 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	K 222		1/14/22

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K 222	Continued From page 3 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 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	K 222		

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K 222	Continued From page 4 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: 1. Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exits throughout the facility. The findings were: Observation on 12/15/2020 at 2:46 PM at the exit door by room 108 revealed that the delayed egress failed to operate as designed. When tested, the release process activated an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds, instead releasing at 30 seconds. Labeling on the door indicated that the door was designed to open after 15 seconds. Further observation found that all doors labeled for releasing after 15 seconds opened at 30 seconds. Interview with the maintenance director at the time of observation acknowledged the delayed egress failure, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (3) 2. Based on observation and staff interview, the	K 222	Correction On or Before 1/14/2022 the Maintenance director will reset the doors to 15 seconds. Maintenance staff will perform a 100% audit on all other egress doors to ensure that the 15 second delayed egress is intact. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	

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K 222	Continued From page 5 facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous exit. The findings were: Observation on 12/15/2021 at 6:30 PM at the exit door for the north dining room revealed the door was locked with a code. The maintenance director was unable to verify that the locking mechanism would release upon activation of the fire alarm system. Interview with the maintenance director at the time of observation acknowledged the locked door. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4, 7.2.1.6.2 .	K 222		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223		1/14/22

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K 223	Continued From page 6 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devises as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous doors with self-closing devices. The findings were: Observation on 12/15/2021 at 3:05 PM at soiled utility room 04 revealed the door was provided with a self-closing device, but failed to close and latch when dropped from an open position. Interview with the maintenance director at the time of observation acknowledged the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1, 7.2.1.8 .	K 223	On or before 1/14/2022 the Maintenance director will replace the closer on the door. Maintenance staff will perform a 100% audit on all other self-closing doors are in compliance. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		1/14/22

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K 293	Continued From page 7 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death. The deficiency affected one (1) of numerous corridors in the facility. The findings were: Observation on 12/15/2021 at 5:54 PM in the corridor between the kitchen, dishwashing, and storage areas revealed that no exit sign could be observed in the corridor. Interview with the maintenance director at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.1.1, 7.10.1.5.1 .	K 293	On or before 1/14/2022 Maintenance Director will put an exit sign above the corridor between the kitchen, dishwashing, and storage areas. Maintenance staff will perform a 100% audit on all other points of egress to ensure that exit signs are in place. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		1/14/22

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K 321	Continued From page 8 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 maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 12/15/2021 at 3:33 PM at the clean linen room across from the oxygen closest in 100 hall revealed that the doors to the corridor and adjacent laundry room were not fire-resistance rated. Interview with the maintenance director and	K 321	On or before 1/14/2022 Maintenance Director will contract the fire doors to be inspected and rated. Maintenance staff will perform a 100% audit on all hazardous areas to ensure fire ratings on doors. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	

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K 321	Continued From page 9 administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2 .	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		1/14/22

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K 324	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to the fire extinguishing system's pull station device in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to maintain accessibility as required could result in injury or death during an emergency. The deficiency affected one (1) of one (1) manual pull stations. The findings were: Observation on 12/15/2021 at 5:34 PM in the kitchen revealed that accessibility to the manual pull station was obstructed due to a large steamer placed in front the device giving a clearance of less than 6 inches. Interview with the maintenance director at the time of observation acknowledged the lack of clearance, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.2.5.1, 9.2.3 2011 NFPA 96, Section 10.5.1 .	K 324	On or before 1/14/2022 Maintenance Director ensure the pull station has the correct clearance Maintenance staff will perform a 100% audit on all pull stations to ensure compliance. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	
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	K 351		1/14/22

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K 351	Continued From page 11 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected two (2) of multiple rooms throughout the facility. The findings were: Observation on 12/15/2021 at 6:02 PM in the soiled utility across from room 408 revealed a fire sprinkler head with an escutcheon that was not flush to the ceiling, which exposed the above-ceiling space above. Escutcheons shall be used to cover the annular space around the sprinkler head. Further observation identified the same condition in the med room at the 400 hall. Interview with the maintenance director at the time of each observation acknowledged the deficiencies, and indicated awareness of the requirement.	K 351	On or before 1/14/2022 Maintenance Director will fix the sprinkler brace in the ceiling for rooms 408 and the other room in hall 400. Maintenance staff will perform a 100% audit on all other sprinkler heads to ensure that the braces are in the correct position. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	

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CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR** **CASPER, WY 82601**

(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
K 351	Continued From page 12 Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 6.2.7.1 .	K 351		
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 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	K 363		1/14/22

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	535024	A. BUILDING **01** B. WING _____	**12/16/2021**

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K 363	Continued From page 13 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 document review and staff interview the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to maintain fire doors could result in injury or death in the event of an emergency. The deficiency affected all fire doors and rolling fire doors. The findings were: Document review on 12/16/21 at 10:00 AM revealed that the facility could not verify that the required annual fire door assembly inspection had been completed. No written record was kept of fire door inspections. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Sections 8.3.3.1 2010 NFPA 80, Section 5.2.1, 5.2.14.3 .	K 363	On or before 1/14/2022 Maintenance Director will complete a house-wide inspection on all fire doors. He will also add this item to the TELS documentation checklist. Maintenance staff will perform a 100% audit on all fire doors to ensure doors are in compliance. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	

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K 712	Continued From page 14	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills could result in injury or death in the event of a fire. The deficiency affected the entire facility. The findings were: Document review on 12/16/21 at 9:24 AM revealed that only one fire drill was conducted in each quarter of 2021. Fire drills are required to be conducted quarterly on each shift. No documented training program could be found that occurred in lieu of this drill. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency.	K 712	On or before 1/14/2022 Maintenance Director will schedule fire drills for each shift in the TELS program Maintenance staff will be educated on this requirement on or before 1/14/2022 Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	1/14/22

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K 712	Continued From page 15 Reference: 2012 NFPA 101 Sections 19.7.1.6 .	K 712		
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. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the facility free of combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the facility free of combustibles as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 12/15/2021 at 6:34 PM at the main lobby revealed two snowmen made from plastic cups and construction paper, snowmen were greater than two (2) feet tall, with a diameter	K 753	On or before 1/14/2022 Maintenance Director will dispose of the plastic snowmen All staff will be educated on this requirement on or before 1/14/2022. A 100% audit of the building will be conducted by maintenance staff to ensure no other flammable decorations are located. Systemic Maintenance will perform weekly check to ensure continued compliance. All check will be documented in the TELS program	1/14/22

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K 753	Continued From page 16 greater than two (2) feet. It could not be established that the decorations had been treated with a fire-retardant chemical. Interview with the maintenance director at the time of observation acknowledged the snowmen, and indicated awareness of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.5.6	K 753	Monitor All follow up and continued checks will be reported to and monitored by the QAPI committee monthly for three months.	