STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING **01** B. WING _____	**01/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	**388 SOUTH US HWY 20** **BASIN, WY 82410**

(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 January 20, 2022. .	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		2/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2022

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 review and update the emergency preparedness plan in accordance with §483.73(a). Failure to develop and maintain the emergency preparedness plan could result in the use of out-of-date information in an emergency. The deficiency affected the emergency preparedness plan. The findings were: Document review on 1/20/2022 at 12:07 PM revealed that the emergency preparedness plan was missing documentation to demonstrate that it was reviewed and updated on an annual basis. Interview with the director of plant operations at the time of observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. .	E 004	E004 (EP Plan, Review and Update Annually) To meet this requirement, the Emergency Management Coordinator will create a cover sheet with document review and revision dates of Emergency Preparedness documents including the facility Emergency Plan. The review cycle will be no less than one year or as requirements change if sooner. The cover sheet indicating appropriate document review completion will be in place no later than February 10, 2022. The EM Coordinator will be responsible for the completion and documentation of the EM Plan review cycle. The plan review will be included on the Emergency Management training and exercise calendar.	
E 041 SS=F	Hospital CAH and LTC Emergency Power	E 041		2/14/22

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E 041	Continued From page 2 CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3)	E 041		

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E 041	Continued From page 3 Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013.	E 041		

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E 041	Continued From page 4 (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to provide proof of fuel reliability in accordance with §483.73(a), 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) . Failure to have proof could result in the generator not functioning in an emergency. The deficiency affected the emergency preparedness plan. The findings were: Interview on 1/20/22 at 11:00 am with the director of plant operations revealed that no letter from the natural gas provider as available to provide proof of low probability of interruption and demonstrated reliability. Interview with the director of plant operations at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. .	E 041	E041 (LTC Emergency Power) To meet this requirement, the Director of Plant Operations will acquire a letter from the natural gas supplier indicating a low probability of interruption of service and reliable supply. This letter will be added to Emergency Management documentation no later than February 14, 2022. The Emergency Management Coordinator will ensure that this letter is maintained as part of the EM Program documentation. A duplicate copy of the letter will be kept with the Emergency Power section of Life Safety documents for the facility.	

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 20, 2022. 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 (000) construction with plan approval in 1973. The building was equipped with a supervised, automatic wet sprinkler system and and an addressable fire alarm system. The facility had a capacity of 37 certified Medicare and Medicaid beds with a census of 24 residents. .	K 000		
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 * 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	K 223		2/10/22

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K 223	Continued From page 6 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 as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous doors with self-closing devices. The findings were: Observation on 1/20/2020 at 10:13 AM at clean utility revealed the self-closing door failed to operate as designed. When dropped tested with no initial motion the door failed to shut and latch. Additional observation at the exit door from the south corridor revealed that the door failed to shut when tested with no initial motion. Interview with the director of plant operations at the time of each observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the facility 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	K223 (Doors with Self-Closing Devices) Maintenance staff will ensure that the self-closing and latching devices for the Clean Utility room are operating properly. In order to ensure ongoing compliance, doors with self-closing devices will be tested for proper operation during the monthly room pressurization checks conducted by maintenance personnel. This will be documented on the "Weekly-Monthly" checklist. Necessary repairs and documentation will be completed no later than February 10, 2022.	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		2/10/22

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K 761	Continued From page 7 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain openings in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain openings as required could result in injury or death during an emergency. The deficiency affected one (1) opening out of many throughout the facility. The findings were: Observation on 1/20/2022 at 9:54 AM at the fire doors separating the nursing home and hospital near the administrator's office revealed that the frame was missing the listing tag. Interview with the director of plant operations at the time of observation acknowledged the missing tag, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.5, 7.2.4.3.1, 8.3.3.1, 8.3.3.2, 8.3.3.2.2 .	K 761	K761 (Maintenance, Inspection & Testing-Doors) The Director of Plant Operations will ensure that the 1 ¿ hour fire door frame separating the Nursing Home from the Old Hospital is certified and labeled as appropriate by a qualified contractor. This work will be completed no later than February 10, 2022. Continued compliance with this requirement will be documented by qualified maintenance personnel during fire door inspections in accordance with NFPA 80.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101	K 911		2/14/22

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K 911	Continued From page 8 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for emergency and standby power systems. The failure to prove reliable access natural gas as required could result in injury or death in an emergency. The deficiency affected one (1) of one (1) generator for the facility. The findings were: Interview on 1/20/22 at 11:00 am with the director of plant operations revealed that no letter from the natural gas provider was available to provide proof of low probability of interruption and demonstrated reliability. Interview with the director of plant operations at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: NFPA 101 Sections 19.5.1, 9.1, 9.1.2, and 9.1.3.1 NFPA 99 Sections 6.4.1, 6.4.1.1, 6.4.1.1.1.2	K 911	K911 (Electrical Systems-Other) To meet this requirement, the Director of Plant Operations will acquire a letter from the natural gas supplier indicating a low probability of interruption of service and reliable supply. This letter will be added to Emergency Management documentation no later than February 14, 2022. The Emergency Management Coordinator will ensure that this letter is maintained as part of the EM Program documentation. A duplicate copy of the letter will be kept with the Emergency Power section of Life Safety documents for the facility.	

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K 911	Continued From page 9 and 6.4.1.1.4 NFPA 110 Section 5.1, 5.1.4	K 911		