STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING **01** B. WING _____	**03/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET** **SUNDANCE, WY 82729**

(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 March 7, 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		5/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2022

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 03/07/2022 at 5:15 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 facility administrator at the time of observation acknowledged the deficiency, and indicated she was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 004	The facility will ensure that the emergency preparedness plan is reviewed and updated at least annually in accordance with 483.73(a). This will be accomplished by: 1)The Emergency Operations Planning Committee will meet quarterly to update and review pertinent information in the emergency plan. 2)The Emergency Preparedness Plan will be revised & reviewed every November of Each year moving forward. 2) Meeting minutes will be maintained by the committee. 3) An audit log of meetings will be maintained by the committee. 4)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 6 months or until the QAPI committee is satisfied that	

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E 004	Continued From page 2	E 004	the facility is in compliance with E0004.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's	E 006		3/24/22

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E 006	Continued From page 3 ability to provide care. *[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. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. 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:	E 006	The facility will ensure that the emergency preparedness plan includes a risk assessment of missing residents in accordance with 483.73(a). This will be accomplished by: 1)The Emergency Operations Planning Committee will meet quarterly to update and review pertinent information in the emergency plan.	

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E 006	Continued From page 4 Document review on 03/07/2022 at 5:20 PM revealed that the emergency preparedness plan did not include the risk assessment of missing residents, as part of their all-hazards approach. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated she was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 006	2)Risk Assessment of Missing Residents, as part of the all-hazards approach has been completed and added to the emergency plan by the committee. The line is titled "LTC Elopement" under the EVENT heading. 3) Meeting minutes will be maintained by the committee. 4) An audit log of meetings will be maintained by the committee. 5)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 6 months or until the QAPI committee is satisfied that the facility is in compliance with E0006.	
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	E 031		3/24/22

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E 031	Continued From page 5 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 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 3/7/2022 at 5:30 PM 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	E 031	The facility will ensure that the emergency preparedness plan contains contact information for local entities as well as federal and state emergency preparedness staff, state licensing and certification agency and the office of the state Long-Term Care Ombudsman in accordance with 483.73(c). This will be accomplished by: 1)The Emergency Operations Planning Committee will meet quarterly to update and review pertinent information in the emergency plan. 2)Missing contact information has been added to the contact list in the emergency preparedness plan by the committee.	

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E 031	Continued From page 6 Long-Term Care Ombudsman. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated she was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 031	3) Meeting minutes will be maintained by the committee. 4) An audit log of meetings will be maintained by the committee. 5)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 6 months or until the QAPI committee is satisfied that the facility is in compliance with E0031.	
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 natural or man-made emergency that requires activation of the emergency plan, the [facility] is	E 039		5/24/22

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E 039	Continued From page 7 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 the emergency plan, the hospital is exempt from engaging in its next required full scale	E 039		

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E 039	Continued From page 8 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: (A) A second full-scale exercise that is community-based or a facility based functional	E 039		

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E 039	Continued From page 9 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 community-based or individual, a facility-based functional exercise; or	E 039		

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E 039	Continued From page 10 (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 community-based or individual, a facility based functional exercise; or	E 039		

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E 039	Continued From page 11 (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 (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a	E 039		

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(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 039	Continued From page 12 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 designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and	E 039		

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	535029	A. BUILDING **01** B. WING _____	**03/07/2022**

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E 039	Continued From page 13 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 plan. (iii) Analyze the HHA's response to and maintain	E 039		

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E 039	Continued From page 14 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises,	E 039		

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E 039	Continued From page 15 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 conduct a second exercise to test the emergency preparedness plan in accordance with §483.73(d). Failure to conduct a second exercise to test the emergency preparedness plan could result in the facility being unprepared in an emergency. The deficiency affected the emergency preparedness plan. The findings were: Document review and interview on 03/07/2022 at 5:45 PM revealed that a second exercise of the emergency preparedness plan was not conducted. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated she was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 039	The facility will ensure that exercises to test the emergency plan are conducted at least twice a year in accordance with 483.73(d). This will be accomplished by: Crook County medical Services District has scheduled a table top exercise for the month of May 2022 and a community wide exercise for the month of July 2022. Processes are in place via bi-weekly meetings of the Emergence Operations Planning Committee to execute this target. The bi-weekly meeting of the EOP Committee is to transition to a quarterly meeting after July and the completions of the drills. The quarterly meeting is in place as a review and update sessions to ensure that the situation does not develop again. Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 6 months or until the QAPI committee is satisfied that the facility is in compliance with E0039.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on March 7, 2022. Requirements for Long Term Care Facilities Section 42 CFR 483.70(a) except as otherwise	K 000		

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K 000	Continued From page 16 provided in this 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 II (111) construction built in 1985. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 32 certified Medicare and Medicaid beds with a census of 25 residents.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of two (2) exits from the facility. Observation on 3/7/2022 at 4:10 PM at the rear exit revealed the exit door could be fully covered with a blackout curtain which would obstruct the visibility of the exit.	K 211	The facility will ensure that means of egress are maintained in accordance with 2012 NFPA 101, Life Safety Code. This has been accomplished by: 1) The blackout curtain has been removed along with the hardware so that the curtain may not be replaced. 2)LTC staff will be educated on Life Safety Code Means of Egress and the importance of maintaining means of egress for all aisles, passageways, corridors, exits and accesses by the LTC	5/24/22

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K 211	Continued From page 17 Interview with the maintenance manager at the time of observation acknowledged that the curtains were used to obscure the exit location, and indicated they were unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 7.1.10.2.1	K 211	DON and Maintenance Manager at the next monthly staff meeting. 3)An audit log of staff education will be maintained by the DON or designee. 4)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with K211.	
K 223 SS=E	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 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 devices as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous doors	K 223	The facility will ensure that the door to the clean linen room inside the bathing room is kept in the closed position. This will be accomplished by: 1) Posting a sign on the door to clean linen room alerting staff to keep the door closed.	5/24/22

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K 223	Continued From page 18 with self-closing devices. The findings were: Observation on 3/07/2022 at 3:42 PM at the clean linen room inside the bathing room revealed the door self-closing had its handle wrapped around the rooms shelving holding the door ajar. Interview with the maintenance manager at the time of observation acknowledged the door being held open, 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, 7.2.1.8.1	K 223	2)LTC staff will be educated on the requirements of self-closing doors per NFPA 101 sections 7.2.1.8.1 and 19.2.2.2.1 by Maintenance Manager and LTC DON at the next monthly staff meeting. 3)An audit log of staff education will be maintained by the DON or designee. 4) An audit log will be completed daily by the maintenance department monitoring that the clean linen room door is closed. 4)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with K223.	
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.	K 362		5/24/22

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K 362	Continued From page 19 If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor separations in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain corridor separations as required could result in injury or death due in an emergency. The deficiency affected one (1) smoke compartment in the facility. The findings were: Observation on 3/07/22 at 3:41 PM in the corridor by room 204 revealed that the ceiling tile nearest the resident room wall had a hole in the tile approximately 1 1/2" by 1 1/2" where by smoke could bypass the ceiling and enter the annular space above. Corridor walls must be maintained to the underside of the floor or roof above, or may terminate at the ceiling if it provides a barrier resistant to the passage of smoke. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: NFPA 101 19.3.6.2	K 362	The facility will ensure that corridor separation is maintained in accordance with Life Safety Code. This will be accomplished by: 1) The observed ceiling tile has been replaced and no holes observed. 2) A monthly observation of walls and ceilings will be performed by the maintenance department. 3) An audit log will be maintained on monthly observations and a work order will be submitted to Maintenance for any deficiencies. 4))Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with K362.	
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101	K 753		5/24/22

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K 753	Continued From page 20 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 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 3/7/2022 at 3:39 PM in the dining/activity area revealed that the space contained an artificial tree. It could not be established that the tree was fire-retardant, or had been treated with an approved fire-retardant coating. Interview with the maintenance manager at the time of observation acknowledged the tree, and indicated awareness of the requirement.	K 753	The facility will ensure that decorations will be maintained in accordance with Life Safety Code. This has been accomplished by: 1) Approved fire retardant spray has been ordered. Expected to arrive 3/30/31. 2)Fire retardant spray will be applied to the artificial tree and all other decorations. Once sprayed, items will be tagged and an audit log will be maintained. New decorations will be sprayed, tagged and logged prior to use and all decorations will then be maintained annually. 3)LTC staff will be educated on Life Safety Code Combustible Decorations by the LTC DON and Maintenance Manager at the next monthly staff meeting.	

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K 753	Continued From page 21 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.5.6	K 753	4)An audit log of staff education will be maintained by the DON or designee. 5)An audit log of treated and tagged decorations will be maintained by the Maintenance department and LTC Activities Director. 6)Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with K753.	
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 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 fire doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire doors as required could	K 761	The facility will ensure that fire doors are maintained in accordance with Fire Safety Code. This will be accomplished by:	5/24/22

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K 761	Continued From page 22 result in injury or death during an emergency. The deficiency affected one (1) of numerous fire doors throughout the facility. The findings were: Observation on 3/7/2022 at 3:32 PM at the fire doors separating the nursing home and hospital, revealed that the frame was missing the listing tag. Interview with the maintenance manager 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	1)CCMSD has contacted the contractor that installed the fire door. The door contractor is in contact with and scheduling a licensed certified fire door inspector to come on-site to inspect and tag the door frame. The referenced door is included in project 2021-031 Crook County Medical Services - Renovation Door Replacement. This is an open project due to direct ties to project 2020-094 Crook County Medical Services Modification Access Control that remains open due to contractor issues. The projects will receive final inspection once both projects are complete.	