STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**12/20/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

(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 12/20/2022. Based upon the findings of the survey team, it was determined the facility was in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 12/19/2022 and 12/20/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 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 built in 1961. The building was equipped with a supervised automatic wet sprinkler system with an wet antifreeze sprinkler system, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 77 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are	K 100		1/17/23

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

Electronically Signed | 01/18/2023

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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K 100	Continued From page 1 deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain ceiling systems in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling systems as required could contribute to the spread of fire during emergency, which may result in injury or death. The deficiency affected one (1) of numerous rooms. The findings were: Observation on 12/19/2022 at 2:42 PM in the kitchen found a hole in the ceiling near the lighting fixture in the southwest quadrant of the kitchen. Further observation found additional holes near electrical conduit in the kitchen where light fixtures had previously been installed. Interview with the facility's staff at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.1	K 100	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K100 General Requirements I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 1/10/2023 a hole in the ceiling near the lighting fixture in the southwest quadrant and additional holes near	

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K 100	Continued From page 2	K 100	electrical conduit in the kitchen have been repaired. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency. By 1/17/23 the maintenance director/designee conducted observations of the facility's ceilings and identified concerns have been corrected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and maintenance team were educated by the NHA/designee on 12/23/22 about the deficiency and requirement to maintain ceiling systems in accordance with the Life Safety Code. Maintenance Team will be responsible for monitoring facility for any new holes found in the facility and repair as needed. The Maintenance Director/Designee will audit facility ceiling systems via observations weekly X 4 weeks, then monthly X 2 months that there are not any new holes in the ceiling in the facility. Any identified concerns will be corrected	

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K 100	Continued From page 3	K 100	immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
K 222 SS=E	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 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	K 222		1/17/23

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K 222	Continued From page 4 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 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	K 222		

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K 222	Continued From page 5 This REQUIREMENT is not met as evidenced by: 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 impede egress during an emergency, which may result in injury or death. The deficiency could impact all residents, staff and visitors in the area. The findings were: Observation on 12/19/2022 at 4:00 PM at the northwest exit revealed the delayed egress locking system failed to operate as designed. When tested, the required force to activate an irreversible process to release the door was 30 lbf. Interview with the facility administrator at the time of observation acknowledged the excess force, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(3)(a)	K 222	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K222 Egress Doors I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 12/22/22 the northwest exit door was fixed; release was adjusted down to 15 lbs. or less to meet the requirements as directed. II. HOW THE FACILITY IDENTIFIED	

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K 222	Continued From page 6	K 222	OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency. By 1/17/23 the maintenance director/designee tested all egress doors to ensure all doors have the appropriate pressure to release. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 12/23/22 the maintenance Director and maintenance team were educated by the NHA/designee about the deficiency and requirement. Maintenance Team will be responsible for monitoring facility's exit doors to ensure the required force to activate an irreversible process to release the door meet the Life Safety Code requirement. The Maintenance Director/Designee will audit egress doors facility weekly X 4 weeks, then monthly X 2 months that all egress doors are within the Life Safety Code weight requirement to open. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO	

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K 222	Continued From page 7	K 222	MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
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 provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching self-closing door as required could contribute to	K 223	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF	1/17/23

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K 223	Continued From page 8 the spread of smoke or fire during an emergency, resulting in injury or death of occupants. The deficiency could impact all residents, staff and visitors located in the areas identified. The findings were: Observation on 12/19/2022 at 2:47 PM at the kitchen storage room revealed that the door failed to latch. When dropped from full open position with no initial motion, it was found that the door failed to fully close and latch. Upon closer inspection, it was found that the door striker plate was bent. Further observation at 4:48 PM at the storage room by room 111 revealed that the self-closing door did not latch when dropped from a full open position. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 7.2.1.8.2	K 223	THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K223 Doors with Self-Closing Devices I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 12/20/22 the kitchen storage room door has been adjusted to self-close fully and latch appropriately. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency.	

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K 223	Continued From page 9	K 223	By 1/17/2023 the Maintenance Director/designee audited all facility doors with self-closing devices to ensure doors fully close and latch. Doors identified have been adjusted. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and the maintenance team were educated on 12/23/22 by the NHA/designee about the deficiency and requirement. Maintenance Team will be responsible for monitoring the facility's doors with self-closing devices to ensure all doors fully close and latch appropriately. The Maintenance Director/Designee will audit the facility's doors with self-closing devices weekly X 4 weeks, then monthly X 2 months that all self-closing doors are operating correctly in the facility per Life Safety Code requirements. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends	

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K 223	Continued From page 10	K 223	and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
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 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 sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected one of numerous storage	K 351	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED	1/17/23

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K 351	Continued From page 11 areas throughout the facility. The findings were: Observation on 12/20/2022 at 3:07 PM in the closet of resident room 148 revealed there was a suitcase stacked within several inches of the sprinkler head, which resulted in an obstruction to the dispersion pattern of the affected sprinkler. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 351	AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K351 Sprinkler System I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 1/16/23 sprinkler system has been reviewed by Western States Fire and a plan is in place to add a sprinkler head into closet space to create coverage for the space as required. Quote is in hand and awaiting Western States to come and do placement of new sprinkler head. The items in resident room 148 have been removed to a different location to avoid an obstruction of the dispersion pattern of the affected sprinkler. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	

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POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

(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	K 351	All residents, staff and visitors have the potential to be affected by this alleged deficiency. By 1/17/23 the maintenance director/designee conducted observations of residents' closets to ensure sprinkler heads are not obstructed. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and the maintenance team were educated on 12/23/22 by the NHA/designee about the deficiency and requirement. Maintenance Team will be responsible to ensure sprinkler heads are not obstructed in storage areas throughout the facility. The Maintenance Director/Designee will audit 10% of facility's storage areas including residents' rooms closets weekly X 4 weeks, then monthly X 2 months that there are not any missing areas covered by sprinkler system in the facility. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report	

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	535025	A. BUILDING **01** B. WING _____	**12/20/2022**

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K 351	Continued From page 13	K 351	findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to conduct fire extinguisher inspections in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to perform extinguisher testing and inspections as required could result in failure of an extinguisher during an emergency, which may result in injury or death. The deficiency could impact residents, staff and visitors throughout the facility. The findings were: Observation on 12/19/2022 at 2:21 PM by room 107 found the fire extinguisher had not been inspected for November of 2022. Further observation found additional fire extinguishers by the outdoor BBQ area, in the main dining room corridor, by room 113, and by room 117/118 had also not been inspected for November of 2022.	K 355	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF	1/17/23

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K 355	Continued From page 14 Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facilities administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 10: Section 7.2.1; 7.2.4	K 355	COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K355 Portable Fire Extinguishers I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 12/20/22 the fire extinguishers by room 107, by the outdoor BBQ area, in the main dining room, by room 113 and by room 117/118 have been inspected. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency. On 12/20/22 all Fire Extinguishers in the facility have been inspected by the maintenance director/designee to meet regulation and requirement. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and the maintenance team were educated on	

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K 355	Continued From page 15	K 355	12/23/22 by the NHA/designee about the deficiency and requirement. Maintenance Team will check and sign off on all fire extinguishers in the facility each month to maintain compliance with the Life Safe Code regulation. The Maintenance Director/Designee will audit all facility's fire extinguishers weekly X 4 weeks, then monthly X 2 months that all fire extinguishers are inspected in the facility timely. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius).	K 781		1/17/23

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K 781	Continued From page 16 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. The failure to provide portable space heaters as required could result in injury or death due to an increased risk of fire. The deficiency affected one (1) of multiple rooms in the facility. The findings were: Observation on 12/19/2022 at 4:33 PM in the admissions office revealed a portable space heater. The area is a non-sleeping staff area, but review of documentation available at the time of the survey was unable to identify the maximum temperature of the heating elements. Interview with the facility manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 19.7.8	K 781	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K781 Portable Space Heaters I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 12/20/22 the identified space heater in the admissions office has been removed from facility in accordance with regulation. II. HOW THE FACILITY IDENTIFIED	

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K 781	Continued From page 17	K 781	OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and the IDT team were educated on 12/23/22 by the NHA/designee about the deficiency and requirement. IDT team and Maintenance Team is responsible to ensure compliance with the requirement that does not allow space heaters in office spaces unless they are within range of heating element requirements. The Maintenance Director/Designee will audit facility's office areas weekly X 4 weeks, then monthly X 2 months that we do not have any space heaters in the facility. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report	

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K 781	Continued From page 18	K 781	findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 923		1/17/23

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K 923	Continued From page 19 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 12/19/2022 at 3:37 PM at the north nurses station revealed an oxygen cylinder sitting unsecured on the floor. Interview with the facility administrator at the time of observation acknowledged the unsecured oxygen cylinder and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99 11.6.2.3(11) 2. Based on observation and staff interview, the facility failed to maintain oxygen storage in excess of 3,000 cubic feet in accordance with the 2012 NFPA 99, Health Care Facilities code. Failure to maintain oxygen storage as required could result in injury or death. The deficiency	K 923	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K923 Gas Equipment-Cylinder and Container Storage I. CORRECTIVE ACTION FOR THOSE	

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K 923	Continued From page 20 affected one (1) of two (2) storage locations at the facility. The findings were: Observation on 12/19/2022 at 4:18 PM revealed that fifteen (15) liquid oxygen containers representing aggregately greater than 18,500 cubic feet was stored outdoors against the building underneath the roof canopy in an unsecured area without a gate. Further observation revealed that the exterior storage location was not separated from the wood-framed building by at least 50 feet as required by NFPA 99 and NFPA 55. Nor was the exterior storage location away from building openings, as it was adjacent to a resident window. Interview with the maintenance manager at time of observation acknowledged the deficiencies, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Section 11.3.2.4; 5.1.3.5.12 and Annex A Figure A.5.1.3.5.12 (a)	K 923	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 12/20/22 the single oxygen container at the north nursing station has been removed from the unsecured floor and since has been stored in the appropriate area. On 12/20/22 all 15 liquid oxygen containers have been removed from the property by the oxygen company that supplied them. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Maintenance Director and team were educated on 12/23/22 by the NHA/designee about the deficiency and requirement. Maintenance Team is responsible for compliance with the requirement for oxygen storage equipment and how to properly store gas cylinders and liquid	

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K 923	Continued From page 21	K 923	oxygen containers. The Maintenance Director/Designee will audit facility's oxygen storage areas weekly X 4 weeks, then monthly X 2 months to ensure gas cylinders and liquid oxygen containers are stored correctly in the facility. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	