STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING **01** B. WING _____	**01/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	**711 ONYX STREET** **KEMMERER, WY 83101**

(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 01/25/2023. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
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), §485.542(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	E 006		1/31/23

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

Electronically Signed | 02/14/2023

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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E 006	Continued From page 1 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 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 provide an emergency preparedness plan including a facility-based and community based risk assessment utilizing an all-hazards approach. The findings were: Review of the emergency preparedness plan on	E 006	E006- On 1/31/2023, Emergency preparedness plan was updated to ensure all hazard approach including transmissible or communicable diseases was addressed in plan. Plan will be reviewed quarterly by safety committee to ensure all hazard approach	

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E 006	Continued From page 2 01/25/2023 starting at 10:00 AM could not establish that the facility had developed a facility and community-based risk assessment utilizing and all hazards approach that included transmissible or communicable diseases. Interview with the facility administrator at the time of review acknowledged that the risk assessment did not address transmissible or communicable diseases.	E 006	compliance.	
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis	E 009		1/31/23

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E 009	Continued From page 3 facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. The findings were: Review of the emergency preparedness plan on 01/25/2023 starting at 10:00 AM revealed that the plan provided a process for contacting and coordinating with local officials, but no process was provided for cooperation and collaboration with tribal, regional, State, or Federal emergency preparedness officials. Interview with the facility administrator at the time of the observation acknowledged the deficiency.	E 009	E009- On 1/31/2023, Emergency preparedness plan was updated to include collaboration and coordination with tribal, regional, state, and federal emergency preparedness officials. Plan will be reviewed quarterly by safety committee to ensure collaboration with appropriate outside organizations.	
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 026		1/31/23

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E 026	Continued From page 4 be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to address the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, for the care and treatment of residents at an alternate care site. The findings were: Review of the emergency preparedness plan on 01/25/2023 starting at 10:00 AM could not establish that the plan included provisions for the care and treatment of residents at an alternate care site per the declaration of an 1135 waiver. Interview with the facility administrator at the time of observation acknowledged the deficiency.	E 026	E026 – On 1/31/2023, Emergency preparedness plan was updated to include provisions for providing care at an alternate site per the declaration of an 1135 waiver. Plan will be reviewed quarterly by safety committee to ensure alternate site remains identified with reference to 1135 waiver.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2)	E 031		1/31/23

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E 031	Continued From page 5 §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), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact 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,	E 031	E031- On 1/31/ 2023, emergency	

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E 031	Continued From page 6 the facility failed to provide contact information for local, tribal, regional, State, and Federal emergency preparedness officials. The findings were: Review of the emergency preparedness plan on 01/25/2023 starting at 10:00 AM revealed that the plan did not include contact information for tribal, regional, State, Federal, and local emergency preparedness staff. Additionally, the plan did not include contact information for the state licensing and certification agency, nor the state long-term care ombudsman. Interview with the facility administrator at the time of the observation acknowledged the lack of contact information. The administrator advised that the plan has recently been updated, and that this information must not have been carried over from the previous plan.	E 031	preparedness plan updated to include contact information for state, federal, and local emergency contacts as well as state licensing and certification agency, and state ombudsman. Plan will be reviewed quarterly by safety committee to ensure contact information provided is up to date.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/25/2023. 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 with a basement of Type II (111) construction built in 1998. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and an addressable fire alarm. The facility had a capacity of 24 certified Medicaid beds with a census of 19 residents. The	K 000		

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K 000	Continued From page 7 findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		3/1/23

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K 222	Continued From page 8 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide egress doors as required could result in injury or death during an emergency. The deficiencies affected three (3) of numerous egress doors throughout the facility. The findings were: Observation on 01/25/2023 at 9:00 AM at the cross-corridor door entrance to the nursing home from the hospital revealed that a WanderGuard system was provided. Additional observation	K 222	K222 SLHD's plant operations department will remove and disable the wander guard system to ensure the egress doors are never locked. The correction will be completed by 03/01/2023. SLHD's maintenance manager will ensure all equipment associated with the wander guard system has been removed and disabled.	

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K 222	Continued From page 9 revealed that a keypad was available to open the door, but that no other means were provided other than moving the WanderGuard bracelet away from the area. Interview with the facility maintenance lead revealed that the control access vendor had visited the facility to make modifications to the door, but he was unsure as to why the door was not provided with a delayed-egress system. Observation on 01/25/2023 starting at 9:10 AM at the dining room egress door, as well as the egress door located at the north end of the resident wing, also revealed a WanderGuard system with the same operation as described for the cross-corridor doors. Interview with the facility maintenance lead at the time of each 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. REF: 2012 NFPA 101, Section 19.2.2.2.5	K 222		
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	K 232		2/14/23

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K 232	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress could hinder egress during an emergency, which could lead to injury or death in the event of an emergency. The deficiency affected two (2) of multiple corridors utilized by patients, staff, and visitors. The findings were: Observation on 01/25/2023 at 9:00 AM at the cross-corridor doors accessing the nursing home from the hospital revealed two (2) linen carts parked at the right egress side of the doors when exiting from the nursing home to the hospital. The location of the carts prevented an occupant from utilizing half of the door opening width. Observation on 01/25/2023 at 9:35 AM in the northern corridor (patient wing) revealed patient lift equipment parked in the corridor, which was not in use. It was observed that the equipment reduces the corridor width to approximately five (5) ft and six (6) inches. Non-emergency medical equipment shall be permitted to be temporarily located within the means of egress if it is in use, does not reduce the egress width to less than 60 inches, and relocation of the equipment is included in the facility's fire safety and training program. Interview with the facility maintenance lead at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time	K 232	K232 SLHD's nursing home staff will ensure all corridors and means of egress are always clear of obstructions other than when patient lifts are being used as per 2012 NFPA 101, section 19.2.3.4. Appropriate storage for lifts has been identified in each end of the corridors, and plan is in place with EVS staff to not leave carts in front of doors. SLHD's nursing home administrator will train staff on the importance of keeping egress routes clear of obstructions, the administrator will also conduct random audits to ensure all means of egress are free of obstructions.	

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K 232	Continued From page 11 of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 19.2.3.4.	K 232		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm ad Signaling Code. Failure to test and maintain the fire alarm system as required could allow system failures to go undetected, which may result in injury or death during an emergency. The deficiency could affect all residents, staff, and visitors within the facility. The findings were: Document review on 01/25/2023 starting at 10:00 AM revealed that semi-annual testing of the fire alarm batteries, and the semi-annual battery load voltage test had been performed in December of 2022, but no additional information was available to demonstrate that a second test had been performed earlier in the year. Testing must be performed on a semi-annual basis.	K 345	K345 SLHD's plant operations department will conduct semi-annual testing of the fire alarm batteries and quarterly testing of the water flow alarm devices and supervisory signal devices in accordance with 2012 NFPA 101, life safety code and the 2010 NFPA 72, national fire alarm and signaling code. SLHD's maintenance manager will ensure all fire system testing is completed and documentation is complete in accordance with NFPA 70, national electric code, and NFPA 72, national fire alarm and signaling code. The Maintenance manager will also ensure that all staff are trained in how to find and print fire system inspection documentation and records upon request.	3/1/23

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	53A051	A. BUILDING **01** B. WING _____	**01/25/2023**

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K 345	Continued From page 12 Document review on 01/25/2023 starting at 10:00 AM revealed that quarterly testing of water flow alarm devices and supervisory signal devices had been performed in December of 2022, but no additional information was available to demonstrate that quarterly testing had been completed throughout 2022. Interview with the facility maintenance lead at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator that the time of exit acknowledged the deficiency.	K 345		
K 353 SS=D	REF: 2010 NFPA 72, Table 14.3.1 and 14.4.5 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		3/1/23

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K 353	Continued From page 13 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system 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. Failure to test and maintain the fire sprinkler system as required could allow system failures to go undetected, which may result in injury or death during an emergency. The deficiency could affect all residents, staff, and visitors within the facility. The findings were: Document review on 01/25/2023 starting at 10:00 AM revealed that no documentation was available to demonstrate testing of the fire protection system's backflow prevention assembly. Backflow prevention systems shall be tested annually. Interview with the facility maintenance lead at the time of the observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deviancy. REF: 2011 NFPA 25, Section 13.6.2	K 353	K353 SLHD's plant operations department will ensure the fire protection system's backflow prevention assembly is tested annually 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. SLHD's plant operations department will ensure testing of the backflow system is completed annually, plant operations will also keep and maintain all fire system documentation.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's	K 521		3/1/23

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K 521	Continued From page 14 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain HVAC systems in accordance with the 2012 NFPA 101, Life Safety Code, 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to test and maintain HVAC systems as required could lead to a delayed or failed response to fire events in the facility, resulting in injury or death. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 01/25/2023 starting at 10:00 AM revealed that the facility had no record of inspection, testing, or maintenance of fire dampers throughout the facility. Fire dampers must be inspected, tested, and maintained at least once during a four (4) year period. Interview with the facility maintenance lead at the time of the 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. REF: 2012 NFPA 101, Section 9.2.1 2012 NFPA 90A; Section 5.4.8.1 2010 NFPA 80, Section 19.4.1	K 521	K521 SLHD will retain an HVAC contractor to inspect and test all facility fire dampers in accordance with the 2012 NFPA life safety code, 2012 NFPA 90A, standard for the installation of air-conditioning and ventilation systems, and the 2010 NFPA 80, standard for fire doors and other opening protectives. SLHD's plant operations department will conduct annual fire damper testing and ensure a licensed HVAC contractor conducts fire damper testing every four years, plant operations will keep and maintain records of inspection, testing and maintenance of dampers.	

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K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide non-combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide non-combustible decorations could contribute to fuel load in the event of a fire, which may result in injury or death. The deficiency had the potential to impact residents, staff, and visitors in the impacted area. The findings were: Observation on 01/25/2023 starting at 9:30 AM in the multi-purpose room revealed an artificial Christmas tree. Interview with the facility maintenance lead at the time of the observation indicated that the tree was constructed of noncombustible materials, but no documentation was provided to verify materials. Additional observation revealed multiple decorative wreaths	K 753	K753 SLHD's plant operations department will discard all holiday decorations not adhering to NFPA 101, NFPA 701, and any decorations that aren't flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. SLHD's plant operations department will inspect all decorations before they are allowed to be displayed in the facility, all decorations not adhering to the NFPA 101 life safety code won't be allowed in the facility. plant operations will keep documentation for all approved decorations.	3/1/23

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K 753	Continued From page 16 located on resident room doors throughout the facility. No documentation was provided at the time of the survey to demonstrate that the wreaths were constructed of non-combustible materials. Interview with the facility maintenance lead 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. REF: 2012 NFPA 101, Section 19.7.5.6	K 753		
K 761 SS=F	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 document review and staff interview, the facility failed to perform annual inspection of fire-rated doors in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA	K 761	K761 A qualified technician in SLHD's plant operations department will conduct annual fire door inspections in accordance with	1/30/23

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K 761	Continued From page 17 80, Standard for Fire Doors and Other Opening Protectives. Failure to inspect fire-rated doors as required could result in equipment failure during an emergency, resulting in injury or death. The deficiency could impact all staff, residents, and visitors within the facility. The findings were: Document review on 01/25/2023 starting at 10:00 AM revealed that inspection of fire-rated doors had not been performed during the past twelve months. Fire-rated doors must be inspected annually. Interview with the facility maintenance lead at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Further interview revealed the facility has attempted to contact their vendor to complete the required inspection, but the vendor has been non-responsive. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 18.7.6 and 4.6.12 2010 NFPA 80, Section 5.2.1	K 761	2010 NFPA 80. The plant operations department will keep and maintain all records of fire door inspections. The plant operations manager will conduct random audits to ensure the fire doors are being inspected in accordance with NFPA 80, the manager will also conduct random audits to ensure all documentation is correct.	