STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING **01, 02** B. WING _____	**01/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	**2009 LARAMIE STREET** **TORRINGTON, WY 82240**

(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 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), §485.542(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	E 004		2/25/23

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

Electronically Signed | 02/17/2023

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E 004	Continued From page 1 all-hazards approach. * [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 during an emergency. The deficiency affected the emergency preparedness plan. The findings were: Document review on 01/25/2023 at 3:20 PM revealed that the emergency preparedness plan was missing documentation 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 they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 004	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. E004 1. The Emergency Plan is being revised to include newly required elements and will be reviewed by the QA committee on 2/23/23. 2. The Emergency Plan has the potential to affect all residents and staff in the facility. 3. The facility has and will continue to	

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E 004	Continued From page 2	E 004	educate regularly on the elements of the Emergency Plan. The facility will provide education to the staff on any new items added to the plan as a result of the revision and review on 2/22/2023. 4. The Administrator is responsible for ensuring that the plan is reviewed annually and contains all of the required elements. 5. Date of completion: 2/25/2023	
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(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 be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		2/25/23

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E 024	Continued From page 3 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility's emergency prepardness plan failed to include a policy for the use of volunteers in an emergency in accordance with §483.73(b)(6). Failure to develop and maintain a policy for the use of volunteers in the facility's emergency preparedness plan could result in insuficient assistance during an emergency. The deficiency affected the emergency preparedness plan. The findings were: Document review on 01/25/2023 at 3:30 PM revealed that the emergency preparedness plan was missing a policy for the use of volunteers during an emergency. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	E 024	E024 1. The Emergency Plan is being revised to include newly required elements and will be reviewed by the QA committee on 2/23/23. The revision includes a statement regarding the use of volunteers in an emergency. 2. The Emergency Plan has the potential to affect all residents and staff in the facility. 3. The facility has and will continue to educate regularly on the elements of the Emergency Plan. The facility will provide education to the staff on any new items added to the plan as a result of the revision and review on 2/22/2023 to include a statement regarding the use of volunteers in an emergency. 4. The Administrator is responsible for ensuring that the plan is reviewed annually and contains all the required elements including a statement regarding	

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E 024	Continued From page 4	E 024	the use of volunteers in an emergency. 5. Date of completion: 2/25/2023	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing,	E 041		2/15/23

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E 041	Continued From page 5 and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 6 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for emergency and standby power systems. The failure to provide a reliable source of fuels for the emergency power system could result in power failure during an emergency, which may lead to injury or death. The deficiency could affect all residents, staff, and visitors within the facility. The findings were: Records review on 01/25/2023 at 3:00 PM with the maintenance manager revealed that no letter from the natural gas provider as available to	E 041	E041 1. A letter was obtained from the natural gas provider as proof of low probability of interruption and reliability. The letter is on file in the Emergency Plan. 2. The Emergency Plan and a natural gas outage has the potential to affect all residents and staff. 3. The Maintenance department was made aware of this requirement and obtained the letter. The Maintenance Director will be in communication with the gas company to renew this letter annually. 4. The Administrator is responsible for	

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E 041	Continued From page 7 provide proof of low probability of interruption and demonstrated reliability. Interview with the maintenance manager at the time of observation acknowledged the deficiency, 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 19.5.1, 9.1, 9.1.2, and 9.1.3.1 2012 NFPA 99, Sections 6.4.1, 6.4.1.1, 6.4.1.1.2 and 6.4.1.1.4 2010 NFPA 110, Section 5.1, 5.1.4	E 041	ensuring that the plan is reviewed annually and contains all the required elements, including this letter. 5. Completion date 2/15/2023	
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 of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the alzheimer building (SCU). The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 69 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		

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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 of Type V (111) construction built in 2008. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the main building (NH). The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 69 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 211 SS=D	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	K 211	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such	2/15/23

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K 211	Continued From page 9 required could delay egress from the building during an emergency, resulting in injury or death. The deficiency affected one (1) of numerous exits. The findings were: Observation on 01/25/2023 at 12:19 PM at the exit north of the main entrance revealed that the sidewalk to the public way was covered snow, and impeded access to the public way. Interview with the maintenance manager at time of observation acknowledged the deficiency, 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: 19.7.3.1; 7.1.10.1	K 211	liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. K211 1. The snow was removed from the cited egress. The egress is an area that is owned by the adjoining hospital, so it had not been routinely attended to by facility or contracted staff. 2. Walking rounds were conducted by the Maintenance Department to observe all outside egress areas. No other areas were found to have ice or snow. 3. The Maintenance Director met with the contractor who provides snow and ice removal and discussed including this area each time snow removal is done. Education was provided to the Maintenance Assistant to also include this egress area on rounds. 4. The Maintenance Director or designee will conduct rounds after each snow removal to observe all outside egress areas to ensure they are free of obstructions including ice and snow. 5. Date of compliance: 2/15/2023	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure,	K 223		2/22/23

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K 223	Continued From page 10 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 and self-closing door as required could lead to the migration of smoke or fire, which may delay egress, resulting in injury or death during an emergency. The deficiency affected one (1) of numerous doors in the facility. The findings were: Observation on 01/25/2023 at 11:10 AM at the kitchen entrance, by the kitchen manager's office, revealed that the door was equipped with a self-closing device, but was held open by a wooden door wedge. Additional observation on 01/25/2023 at 11:17 AM at the kitchen janitor's closet revealed that the door was equipped with a self-closing device, but was held open by a toilet brush. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 223	K223 1. Both items holding open the self-closing doors in the kitchen were removed at the time of the survey. 2. Rounds were conducted by the maintenance department to observe all self-closing doors. No other devices were obstructing doors. 3. The dietary staff and maintenance assistant will be educated on keeping these doors closed unless using them. This education will be repeated at the all-staff meeting on 2/22/23 as it applies to all doors with self- closures. Observations of self-closing doors is part of the TELS preventive maintenance system and is reviewed regularly. 4. The Dietary Manager is responsible for monitoring the doors cited in the kitchen. Problems with the doors will be reported to the Maintenance Director and the QA committee for review and resolution.	

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K 223	Continued From page 11 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	5. Date of completion: 2/22/2023	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking equipment in	K 324	K324	2/15/23

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	535057	A. BUILDING **01, 02** B. WING _____	**01/25/2023**

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K 324	Continued From page 12 accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were: Observation on 01/25/2023 at 1:29 PM in the kitchen revealed a wheeled gas-fired cooktop and other cooking equipment located beneath the grease hood and fire suppression system. Further observation revealed that no means was provided to ensure that the cooktop is returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Interview with the maintenance manager at the time of observation acknowledged the deficiency, 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 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K 324	1. Gas stove stoppers were installed on the floor that hold the stove in place. 2. Another kitchen exits in the facility with a gas stove. Stoppers were also installed on the floor to hold the stove in place. 3. Dietary staff were educated on the placement of the stoves inside the stoppers after moving the stove for cleaning. This places the stove in the correct position under the hood. 4. The dietary manager is responsible to monitor the position of the stove under the hood. The Maintenance Department will conduct regular audits of the stove locations as part of the TELS preventive maintenance program. Problems with this process will be brought to the QA committee for review and resolution. 5. Date of completion: 2/15/2023	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351		2/15/23

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K 351	Continued From page 13 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: 1. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous rooms. The findings were: Observation on 1/25/2023 at 12:36 PM in the Bathroom on the 400 hall revealed the escutcheon and sprinkler head dropped down from the ceiling. When moved, it appeared that the hanger may not be functioning as intended. Interview with the maintenance manager at the time of observations acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency.	K 351	K351 1. The sprinkler hanger was repaired in the bathroom on the 400 hall. The sprinkler outside the 400 hall was cleaned to remove material obstructing the sprinkler head. 2. Rounds were conducted to observe all bathroom and outside sprinkler heads. No other problems were identified. 3. The maintenance assistant was educated on the need to ensure all sprinklers are properly installed and free of obstruction. Observation of the sprinkler heads throughout the facility are part of the TELS preventive maintenance program and are reviewed regularly. The outside sprinkler heads were specifically added to the PM program for regular observations. 4. The Maintenance Director is responsible to monitor this process.	

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K 351	Continued From page 14 REF: 2010 NFPA 13, Sections: 9.2 2. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous rooms. The findings were: Observation on 1/25/2023 at 12:51 PM outside and above the exit door of the 400 hall revealed that the escutcheon and sprinkler head had a cage around it. Further observation revealed that a bird's nest and dropping were obstructing the sprinkler head. Interview with the maintenance manager at the time of observations acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency.	K 351	Problems with this process will be brought to the QA committee for review and resolution. 5. Date of completion: 2/15/2023	
K 511 SS=D	REF: 2010 NFPA 13, Sections: 8.7.5 Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.	K 511		1/25/23

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K 511	Continued From page 15 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 1/25/2023 at 4:05 PM in the alzhiemier unit revealed an electrical outlet without a cover. Further observation revealed the juice dispenser was plugged into the receptacle. Interview with the facility 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: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 406.6	K 511	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. K511 1. The electrical outlet cover was replaced on the day of the survey. 2. The Maintenance Department conducted walking rounds of the facility to observe for similar concerns. None were found. 3. The Maintenance Assistant was educated on the need to have covers on all electrical outlets. Observations of the electrical outlets will be conducted as part of the TELS preventive maintenance program when checking for electrical power cord concerns. 4. The Maintenance Director is responsible for this process. Problems with this process will be brought to the QA committee for review and resolution.	

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K 511	Continued From page 16	K 511	5. Completion date: 1/25/2023	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the facility free of combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the facility free of combustibles as required could lead to the propagation of smoke and fire, which may result in injury or death during an emergency. The deficiency could impact all residents, staff, and visitors within the affected area. The findings were: Observation on 1/25/2023 at 12:29 PM in the activity room revealed a plastic pine tree decorated for valentines day, whereby the fire protection of which could not be established.	K 753	K753 1. The Christmas tree in the activity room was removed and stored in an offsite storage area. Flame retardant spray was ordered. A log was developed to list each artificial Christmas tree used for decoration annually. Trees will be sprayed prior to entering the facility. 2. The Maintenance Department conducted rounds to observe the facility for other items that may need to be sprayed and logged. No other items were identified. 3. The Maintenance and Activities staff	2/22/23

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K 753	Continued From page 17 Interview with the maintenance manager at the time of observation acknowledged the tree, 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: 19.7.5.6	K 753	were educated on the procedure for spraying decorations with flame retardant spray prior to use in the facility. This education will be repeated at the all-staff meeting on 2/22/2023. A log of each treatment will be kept in the Maintenance department. 4. The Maintenance Director is responsible for this process. Problems with this process will be brought to the QA committee for review and resolution. 5. Date of completion: 2/22/2023	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for emergency and standby power systems. The failure to provide a reliable source of fuels for the emergency power system could result in power failure during an emergency, which may lead to injury or death. The deficiency could affect all residents, staff, and visitors within the facility. The findings were:	K 911	K911 1. A letter was obtained from the Gas Company discussing the low probability of an outage and systems in place to prevent and handle an outage. The letter is on file in the Emergency Procedures Manual. 2. A gas outage has the potential to affect all residents and staff. 3. The Maintenance Assistant was educated on the requirement for this letter to be on file to demonstrate reliability of the natural gas provider.	2/15/23

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K 911	Continued From page 18 Records review on 1/25/2022 at 3:00 PM with the maintenance manager revealed that no letter from the natural gas provider as available to provide proof of low probability of interruption and demonstrated reliability. Interview with the maintenance manager at the time of observation acknowledged the deficiency, 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 19.5.1, 9.1, 9.1.2, and 9.1.3.1 2012 NFPA 99, Sections 6.4.1, 6.4.1.1, 6.4.1.1.1.2 and 6.4.1.1.4 2010 NFPA 110, Section 5.1, 5.1.4	K 911	4. The Maintenance Director is responsible for obtaining this letter and communicating directly with the gas company. Problems with this process will be brought to the QA committee for review and resolution. 5. Date of compliance: 2/15/2023	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical equipment as required could cause an unsafe work	K 919	K919 1. The cleaning supplies in the kitchen maintenance room were moved away from the electrical panels to ensure a working space of 3 feet.	2/22/23

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K 919	Continued From page 19 environment, and may result in injury or death for staff or maintenance personnel when attempting to service the equipment. The deficiency could impact all staff, or service personnel, that may interact with the equipment. The findings were: Observation on 1/25/2023 at 1:21 PM in the kitchen maintenance room revealed that several pallets of cleaning supplies were being stored in front of several electrical panels. A working space of three (3) feet is to be maintained. 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: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	2. There are eight (8) areas with electrical panels in the facility that require a 3-foot working space without obstruction. The Maintenance Department conducted walking rounds to observe these eight (8) areas. No other problems were identified. 3. Education regarding the 3-foot space in front of all electrical panels was conducted with the housekeeping and dietary departments. The education will be repeated at the all-staff meeting on 2/22/2023. Weekly rounds are conducted to observe these areas as part of the TELS preventive maintenance program. Each of the eight (8) areas are now specifically logged in TELS. 4. The Maintenance Director is responsible for ensuring that these areas are kept clear. Problems with this process will be brought to the QA committee for review and resolution. 5. Date of compliance: 2/22/2023	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		2/22/23

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K 920	Continued From page 20 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70 National Electrical Code. The failure to maintain electrical equipment as required could result in an increased risk of electric shock, which may lead to injury or death. The deficiency could affect residents, staff, or visitors that attempt to use each device. The findings were: Observation on 01/25/2023 at 12:42 PM at the 400 hall Nurses Station revealed that a surge protector was plugged into a surge protector, creating a daisy chain. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Section 9.1.2	K 920	K920 1. The power strip that had been plugged into another power strip was removed on the day of the survey. 2. The Maintenance Department conducted walking rounds of the facility to observe for other similar power cord concerns. None were found. 3. Education will be provided to all-staff at a 2/22/2023 meeting. The maintenance department conducts weekly rounds of all areas in the facility to observe for extension cords or other power cord concerns as part of the TELS preventive maintenance program. 4. The Maintenance Director is responsible for this process. Problems with this process will be brought to the QA committee for review and resolution. 5. Date of compliance: 2/22/2023	

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K 920	Continued From page 21 2011 NFPA 70, Section 400.8	K 920		