

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2023	
NAME OF PROVIDER OR SUPPLIER BIG HORN REHABILITATION AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1851 BIG HORN AVE SHERIDAN, WY 82801			
(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			E 000			
E 031 SS=F	An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 02/08/2023. The findings that follow demonstrate noncompliance with 42 CFR 483.73. Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(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			E 031			2/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/06/2023

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 031	Continued From page 1 information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to develop and maintain the emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. The findings were: Document review on 02/08/2023 at 1:30 PM revealed that the contact list in the emergency preparedness plan was missing contact information for: Federal and State emergency preparedness staff and the Office of the State Long-Term Care Ombudsman. 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 031	E031 – Emergency Officials Contact Information 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. ¿ I. CORRECTIVE ACTION FOR THE DEFICIENT PRACTICE: The contact information for required Federal, State, regional, and local		

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E 031	Continued From page 2	E 031	emergency preparedness staff was added to the communication roster within the Emergency Preparedness binder. The contact information regarding the Long-term care Ombudsman office was added to the communication roster in the Emergency Preparedness binder. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Starting 2/10/2023 the Maintenance Director and the NHA were educated on the importance of including all necessary emergency contact in the EP binder. The maintenance director will complete a full audit of all emergency contact information within the EP binders throughout the facility. The Maintenance Director/Designee will complete a facility audit of all EP binders to ensure proper emergency communication roster weekly x 4, then monthly x 2. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:		

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E 031	Continued From page 3	E 031	The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
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)	E 041	⌚ Date of Compliance: 2/10/2023		3/2/23

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E 041	Continued From page 4 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, 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 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	E 041			

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E 041	Continued From page 5 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (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:	E 041			

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E 041	Continued From page 6 Based on document review and staff interview, the facility failed to provide a letter of reliability in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Healthcare Facilities Code, and NFPA 110, Standard for emergency and standby power systems. The failure to prove reliable access natural gas as required could result in failure of the emergency power system, which may lead to injury or death in an emergency. The deficiency affected one (1) of one (1) generator for the facility. The findings were: Document review on 02/08/2023 at 12:50 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	E 041	E041 Hospital CAH and LTC Emergency Power 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Montana -Dakota Utilities contacted for a letter of reliability of service. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:		

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E 041	Continued From page 7	E 041	All residents are at risk to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director/Designee and the NHA received education about the requirement of having a letter of continued service in the Emergency Preparedness binder. A letter is obtained and placed in each of the EP binders. The Maintenance Director/Designee will complete a facility audit of all EP binders to ensure proper emergency communication roster weekly x 4, then monthly x 2. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance		

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E 041	Continued From page 8	E 041	Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 02/08/2023. 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 1962 and 1988. The building was equipped with a supervised, automatic dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 76.	K 000	Date of Compliance: 3/2/2023		
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	K 223			2/10/23

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K 223	Continued From page 9 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 delay egress resulting in injury or death during an emergency. The deficiency affected three (3) of numerous doors in the facility. The findings were: Observation on 02/08/2023 at 10:33 AM at the clean utility in the 100 hall revealed that the door was equipped with a self-closing device, but that the latching mechanism had been removed from the door hardware, rendering it incapable of latching when released with no initial motion. Additional observation on 02/08/2023 at 10:46 AM at the fire barrier doors by the main entrance revealed that the door was equipped with a self-closing device, but failed to latch on one of the two doors when released with no initial motion. Additional observation on 02/08/2023 at 12:08 PM at the kitchen door found when released with no initial motion that it failed to latch. 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.	K 223	K223 Doors with Self-Closing Devices 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The door to the clean utility room on the		

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K 223	Continued From page 10 REF: 2012 NFPA 101: Section 7.2.1.8.2	K 223	100 hall replaced and repaired the latch mechanism. The fire door at the main entrance adjusted/replaced latch. The main kitchen door closure was adjusted for proper closing. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN The Maintenance Director/Designee and the NHA received education about the requirement of doors with self-closing devices to be in proper working order. All self-closing doors in the facility were audited to ensure proper working order. The Maintenance Director/Designee will complete a facility audit of all self-closing doors to ensure proper working order weekly x 4, then monthly x 2. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance		

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NAME OF PROVIDER OR SUPPLIER BIG HORN REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1851 BIG HORN AVE SHERIDAN, WY 82801		
(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 223	Continued From page 11	K 223	Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. .		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	Date of Compliance: 02/10/2023	2/28/23	

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K 321	Continued From page 12 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a door to a hazardous area in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a door to a hazardous area as required could 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 02/08/2023 at 12:06 PM at the kitchen storage room revealed that no door was installed to separate the storage room from the kitchen. 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: Section 19.3.2.1	K 321	K321 Hazardous Areas - Enclosure 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN		

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K 321	Continued From page 13	K 321	AFFECTED BY THE DEFICIENT PRACTICE: The door separating the storage area from the kitchen was re-hung and tested for proper working order. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN Starting 2/10/23 Maintenance Department and NHA were educated on the proper working condition and order of the door separating the kitchen from storage. Maintenance director/designee will complete an audit weekly x4 and then monthly x 2. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI		

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K 321	Continued From page 14	K 321	Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
K 345 SS=D	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 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The finding was: Document review on 02/08/2023 at 12:40 PM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. The facility	K 345	Date of Compliance: 3/01/2023 K345 Fire Alarm Testing and Maintenance 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	3/1/23	

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K 345	Continued From page 15 provided both the annual and semi-annual inspection reports pertaining to the previous twelve (12) months, but only the semi-annual report included battery testing information. 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: 2010 NFPA 72 Table 14.3.1(3)(d)	K 345	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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Fire alarm system were tested on 2/8/2023. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The fire alarm system batteries were tested immediately. Education completed on 2/10/2023 with Maintenance department and NHA on testing of the fire alarm system batteries		

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K 345	Continued From page 16	K 345	The Maintenance Director and/or designee will complete an audit weekly x4 and then monthly x 2 of the fire alarm battery system. Schedule created in TELS program on testing time of the batteries every six months. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ⌚ Date of Compliance: 3/01/2023		
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 approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		3/1/23	

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K 351	Continued From page 17 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 have sprinkler systems installed in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The failure to install sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the walk-in fridge and freezer. The findings were: Observation on 02/08/2023 at 12:01 PM in the walk in kitchen freezer and refrigerator revealed the color of the sprinkler bulb fluid to be red, which indicates an in appropriate sprinkler type for the application. 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 administrator at the time of exit acknowledged the deficiency.	K 351	K351 Sprinkler System - Installation 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.		

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K 351	Continued From page 18 REF: 2010 NFPA 13, Section 8.3.2.5, Table 6.2.5.1 2. Based on observation and staff interview, the facility failed to have sprinkler systems installed in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The failure to install sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the required maintenance equipment for the sprinkler system. The findings were: Observation on 02/08/2023 at 10:56 AM in the basement mechanical room revealed that no sprinkler wrench was present at the spare sprinkler box. 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 administrator at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 13, Section 6.2.9.6 3. Based on observation and staff interview, the facility failed to have sprinkler systems installed in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The failure to install sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the fire sprinkler system, and the facility's ability to ensure proper operation. The findings were: Observation on 2/08/2023 at 12:23 PM in the	K 351	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Fire system company reviewed the requirements and ordered the correct time of sprinkler for the walk-in coolers. A sprinkler wrench was placed on top of the spare sprinkler head box. Hydraulic plates are on the east system. According to our representation with 406 Fire System Inspection and Installation, the west boiler uses pipe schedule system and is not hydraulically calculated due to its age. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk for the deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed for the maintenance department and the NHA on the proper sprinkler heads, Sprinkler Wrench placement as well as the need of a Hydraulic Calculation Plate on boiler systems when applicable. On 2/10/2023 the Maintenance Director/designee will audit all sprinkler systems, sprinkler wrench locations, and hydraulic		

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K 351	Continued From page 19 main boiler room revealed no hydraulic design information nameplate was provided on the fire sprinkler riser as prescribed. 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 administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.1.1(1) 2010 NFPA 13, Section 24.5.1	K 351	calculation plates weekly x 4, then monthly x 2. Any findings will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: ¿ The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
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). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by:	K 781	¿Date of Compliance: 3/1/2023	2/10/23	

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K 781	Continued From page 20 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 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 02/08/2023 at 11:23 AM in the business office revealed a portable space heater. The area is a non-sleeping staff area, however it was not possible to determine 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	K781 Portable Space Heaters 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The portable space heater was removed from the building. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk for the deficient		

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K 781	Continued From page 21	K 781	practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The maintenance director/designee audited all office in the building to ensure no space heaters are in use. Education was done with staff about not having portable space heaters in the building. The maintenance director/designee will audit offices weekly x 4 then monthly x 2 to make sure not portable space heaters are in use. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿ Date of Compliance: 2/10/2023		

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K 911 K 911 SS=F	Continued From page 22 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 prove reliable access natural gas as required could result in failure of the emergency room power system, which may lead to injury or death in an emergency. The deficiency affected one (1) of one (1) generator for the facility. The findings were: Document review on 2/08/2023 at 12:50 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.	K 911 K 911	K911 Electrical Systems Other 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. ¿	3/2/23	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2023
NAME OF PROVIDER OR SUPPLIER BIG HORN REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1851 BIG HORN AVE SHERIDAN, WY 82801		
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K 911	Continued From page 23 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	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Montana -Dakota Utilities contacted for a letter of reliability of service. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director/Designee and the NHA received education about the requirement of having a letter of continued service in the Emergency Preparedness binder. A letter is obtained and placed in each of the EP binders. The Maintenance Director/Designee will complete a facility audit of all EP binders to ensure proper emergency communication roster weekly x 4, then monthly x 2. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:		

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K 911	Continued From page 24	K 911	The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
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) assemblies 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 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.	K 920	Date of Compliance: 3/02/2023	2/10/23	

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K 920	Continued From page 25 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 provide 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 injury or death due in an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 02/08/2023 at 11:23 PM in the business office 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 2011 NFPA 70, Section 400.8	K 920	K920 Electrical Power Cords and Extens CFR 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:		

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K 920	Continued From page 26	K 920	Removed the daisy-chained surge protectors and the proper extension place. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk to be affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to IDT team on proper use of electrical extensions on 2/10/2023. Maintenance Department will complete an audit weekly for 4 weeks, then monthly for 2 months to ensure no improper electrical extensions are in use. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: ⌚ The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance		

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K 920	Continued From page 27	K 920	Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage 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." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923	Date of Compliance: 2/10/2023	3/1/23	

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K 923	Continued From page 28 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: 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 affected one (1) of one (1) storage locations at the facility. The findings were: Observation on 02/08/2023 at 1:10 PM revealed that nine (9) liquid oxygen containers representing aggregately greater than 11,000 cubic feet was stored outdoors in an unsecured area with two doors whereby one of the doors no longer had a latch to be capable of securing the interior. Further observation found that only one of the two doors had a sign indicating the storage of oxidizing gas(es) was contained within. 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 11.3.1; 5.1.3.3.2(2), 11.3.4.1, 11.3.4.2	K 923	K923 Gas Equipment – Cylinder and Container Storage 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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:		

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K 923	Continued From page 29	K 923	The nine liquid oxygen e-tanks were removed by the oxygen company. Signage state No Smoking, Danger Flammable material, Caution Oxidizing Gasses stored within, No Smoking warning were ordered for transfilling station. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed for the maintenance department on the proper storage of liquid oxygen cylinders. Education was provided for maintenance department regarding proper sign placement at the transfilling station on 2/10/2023. Maintenance director/designee will complete an audit weekly x 4 then monthly x 2 to ensure proper storage for cylinders and proper placement of signage. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly		

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K 923	Continued From page 30	K 923	Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023 i		
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen transfilling areas in accordance with the 2012 NFPA 99, Health Care Facilities code. Failure to maintain oxygen transfilling locations as required could result in	K 927	FK927 Gas Equipment Transfilling Cylinders CFRs PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT	3/3/23	

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K 927	Continued From page 31 injury or death. The deficiency affected one (1) of one (1) transfilling locations at the facility. The findings were: Observation on 02/08/2023 at 1:10 PM revealed that liquid oxygen containers used for transfilling portable tanks were stored outdoors in an enclosure with two doors. Whereby only one of the two doors had a sign indicating the transfilling of oxidizing gas(es) was contained within. 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 99, Section 11.5.2.3.1(3), 11.5.2.3.2(2)	K 927	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. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Additional signage ordered to be placed on all four sides of the transfilling station. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE		

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K 927	Continued From page 32	K 927	DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed with maintenance department about proper signage on the transfilling station. Audits will be completed weekly x 4 then monthly x 2 by the maintenance director/designee. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/3/2023		