STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**05/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 05/23/2023. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
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)	E 041		6/23/23

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

Electronically Signed | 06/19/2023

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E 041	Continued From page 1 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 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	E 041		

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E 041	Continued From page 2 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: Based on document review and staff interview, the facility failed to exercise the generator in accordance with the 42 CFR 483.73 - Emergency preparedness, and the NFPA 110, Standard for Emergency and Standby Power Systems. Failure to exercise the generator could result in the generator not functioning in an emergency. The deficiency affected the generator load tests. The findings were: Document review on 05/23/2023 at 2:50 PM revealed that generator load testing had been performed, but had only ran for 0.3 hours once a	E 041	Preparation and execution of the 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 s prepared and/or executed solely because it is required by the provisions of the state and federal 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	

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E 041	Continued From page 3 month. Diesel generators shall be exercised monthly for 30 minutes. 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: CFR §483.73(e)(2) 2010 NFPA 110, Sections: 8.4.2, 8.4.2.3	E 041	constitutes the facility's allegation of compliance in accordance with the State Operations Manual. E0041 Corrective Action On 6/19/23 the emergency generator was exercised under load for 30 minutes and recorded by the Maintenance Director. Identification of Others Residents have a potential to be affected by this practice. The facility only has 1 emergency generator. Systemic Change In-service education was provided to the Maintenance staff related to the 30-minute generator exercise on 6/16/23. The Maintenance Director monitors the 30-minute generator exercise monthly to validate that the it runs for the required 30 minutes and that the test is recorded. Monitoring The Maintenance Director brings the results of the of the emergency generator monthly exercise audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued	

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E 041	Continued From page 4	E 041	at that time unless the QAPI Committee deems it prudent to continue.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 05/23/2023. 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, three story building with a basement of a Type II (222), and Type II (111) construction built in 1966 and 1972. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 82 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain ceiling systems in	K 100	Preparation and execution of the response and plan of correction does not	6/23/23

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K 100	Continued From page 5 accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling systems as required could contribute to smoke spread throughout the facility, or could delay the response time of fire suppression systems during an emergency. The deficiency was widespread throughout the facility, and could impact all residents, staff, and visitors. The findings were: Observation on 5/23/2023 at 8:30 AM in the central supply revealed a missing ceiling tile. Interview with maintenance manager revealed that the tile had been removed to prevent water damage to the tile due to an ongoing leak that has not been located. Further observations found missing ceiling tiles in the medical records office and room, which had been moved to replace the gas line to the kitchen that had been completed more than a month before survey. Further observation found ceiling tiles not in place throughout the building. 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 19.1.1.1.3, 4.6.12.1	K 100	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 s prepared and/or executed solely because it is required by the provisions of the state and federal 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 the State Operations Manual. K 100 Ceiling Tile Placement Corrective Action The ceiling tiles in central supply, medical records and the basement bathroom were moved back into proper position on 5/24/23. Identification of Others The Maintenance Director conducted and audit of the center on 5/24/23 to identify any other ceiling tiles were out of place. None were found. Systemic Change In-service education was provided to the Maintenance Department by the Executive Director on 6/16/23 regarding the requirement of ceiling tiles being properly placed at all times.	

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K 100	Continued From page 6	K 100	The Maintenance Director/designee audits the ceiling tiles throughout the center 1 time monthly to validate that ceiling tiles are in place. Monitoring The Maintenance Director brings the results of the of the ceiling tile audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue 1 time a monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222		6/23/23

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K 222	Continued From page 7 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised	K 222		

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K 222	Continued From page 8 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected one (1) of multiple exit doors in the facility. The findings were: 1. Observation on 05/23/2023 at 10:00 AM at the south exit west of the rehab area revealed the delayed egress locking system operated as designed, but once the lock was released, the door took excessive force to open fully. 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: 19.2.2.2.1; 7.2.1.4.5 2. Observation on 05/23/2023 at 10:02 AM at delayed egress door leading to the stairwell exit across from rehab revealed the delayed egress locking system operated as designed, but failed to have a sign posted labeling the door as a delayed egress. Interview with the maintenance manager at the time of observation acknowledged the deficiency,	K 222	K 222 Egress Doors Corrective Action The south exit door west of the rehab area was filed so that it no longer requires excessive force to fully open on 5/26/23. A sticker was placed on the delayed egress door across from rehab indicating it as a delayed egress on 5/23/23. Identification of Others The Maintenance Director checked exit doors on 5/24/23 to ensure they did not require excessive force to fully open. Doors are fully functional. The Maintenance Director check delayed egress doors to validate signage that indicated delayed egress on 5/24/23. Doors are labeled appropriately. Systemic Change In-service education was provided to the Maintenance staff related to the requirement of exit doors to open without excessive force and egress doors to have proper signage by the Executive Director on 6/16/23 The Maintenance Director/designee audits exit doors to ensure that they do	

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K 222	Continued From page 9 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: 19.2.2.2.4(2); 7.2.1.6.1.1(4)	K 222	not require excessive force and all egress doors for proper signage monthly. Monitoring The Maintenance brings the results of the of exit and egress door audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 324 SS=E	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	K 324		6/23/23

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K 324	Continued From page 10 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to protect cooking equipment in 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 05/23/2023 at 9:36 AM in the kitchen revealed a wheeled gas-fired cooktop 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	K 324 Cooking Facilities Corrective Action On 5/24/23 the Maintenance Director painted circles on the floor to indicate proper placement of the wheeled gas-fired cooktop under the grease hood and fire suppression system. The Maintenance staff was provided in-service education as to the requirement for the timing of the kitchen hood extinguishing system inspections on 6/16/23. Identification of Others Residents have a potential to be affected by this practice. The facility only has 1 wheeled gas-fired cooktop. Residents have a potential to be affected by this practice. The facility only has 1 kitchen hood. Systemic Change The Maintenance staff was provided in-service education on 6/16/23 by the Executive Director regarding the requirement to have a means in place to	

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K 324	Continued From page 11 2. Based on document review and staff interview, the facility failed to have the kitchen extinguishing system inspected in 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 have the kitchen extinguishing system inspected as required could result in injury or death during an emergency. The deficiency affected one (1) of one (1) kitchens in the facility. The findings were: Document review and staff interview on 05/23/2023 at 2:42 PM revealed that two inspections of the kitchen hood had been completed, but that a period of 7 months had passed before the system was inspected for the second time. 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: 19.3.2.5.1, 9.2.3 2011 NFPA 96, Sections: 11.5	K 324	ensure that the cooktop is returned to the approved location. The Maintenance Director/designee checks the floor for the painted circles monthly to validate that the paint is still visible. If paint is questionable the circles are repainted. The Maintenance staff was provided in-service education as to the requirement for the timing of the kitchen hood extinguishing system inspections on 6/16/23 by the Executive Director. The Maintenance Director/designee audits the records of the kitchen hood extinguishing system monthly to validate that inspections are up to date. Monitoring The Maintenance Director brings the results of the of the cooktop placement audits and the monthly review of the records for the kitchen hood extinguishing system to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		6/23/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 12 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: 1. Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Observation on 05/23/2023 at 9:09 AM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm was expired. 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 Sections 19.3.4.1; 9.6.1.3 2010 NFPA 72 Section 26.3.4.3 2. Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA	K 345	K 345 UL Cert on Fire Panel Corrective Action The Maintenance Director received the UL Certification from the vendor for the Fire Panel on 5/23/23 and placed it at the annunciator panel. The fire alarm system batteries were inspected on 6/19/23. Identification of Others residents have the potential to be affected by this practice. Systemic Change The Maintenance Department was provided in-service education by the Executive Director regarding the requirement to maintain a current UL Certificate for the fire panel on 6/16/23 The Maintenance Director/designee visually inspects the UL Certificate for the fire panel monthly to validate it is present and current. If it is not present or if it is	

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K 345	Continued From page 13 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, and could impact all residents, staff, and visitors within the facility. The findings were: Document review on 05/23/2023 at 2:42 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. 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	about to expire he contacts the vendor for a current certificate. The Maintenance staff was provided in-service education related to having the fire alarm system batteries inspected every 6 months by the Executive Director on 6/16/23. The Maintenance Director audits the records of the fire alarm system batteries monthly to validate that they are inspected timely. Monitoring The Maintenance Director brings the results of the of the UL Certificate Audit and the fire alarm system batteries to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue once a month for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		6/23/23

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K 351	Continued From page 14 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 hinder maintenance and repair of the sprinkler system, which may result in system malfunction during the emergency. The deficiency affected the sprinkler riser room. The findings were: Observation on 05/23/23 at 8:24 AM in the basement mechanical/elevator 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 aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2010 NFPA 13, Section 6.2.9.6 2. Based on observation and staff interview, the	K 351	K 351 Sprinkler System Installation Corrective Action The Maintenance Director found the missing sprinkler wrench beneath the box on 6/7/23 and placed back inside the box. The 2 missing escutcheons on the north side of the rehab room were replaced on 6/15/23. Identification of Others The second box was checked to ensure that the wrench was in the box. The wrench was present and available for use. The Maintenance Director audited the facility on 5/24/23 for any missing escutcheons. None were found. Systemic Change In-service education was provided to the Maintenance staff on 6/16/23 by the	

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K 351	Continued From page 15 facility failed to to install the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly install the fire sprinkler system could inhabit proper operation of the suppression system during an emergency. The deficiency affected two (2) of multiple sprinkler heads throughout the facility. The findings were: Observation on 05/23/2023 at 9:53 AM at the northside of the rehab room revealed two fire sprinkler heads with missing escutcheons, exposing the annular space above. 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 13, Sections: 6.2.7.1	K 351	Executive Director regarding the requirement to have a wrench available at all times in the sprinkle box for emergency situations. The Maintenance Director/designee audits the sprinkler boxes 1 time per month to validate the wrench is available for use. If the wrench is not located in the box, it is replaced immediately as the facility now has a spare wrench on hand. In-service education was proved to the Maintenance staff related to the requirement of escutcheons on sprinkler heads on 6/16/23. The Maintenance Director/Designee checks all sprinkler heads for escutcheon month to verify that none are missing. Any identified as missing are replaced. Monitoring The Maintenance brings the results of the of the sprinkler wrench audits and escutcheon audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		6/23/23

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K 353	Continued From page 16 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1. Based on document review and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in system malfunction during an emergency, which could impact all resident, staff, and visitors within the facility. The findings were: Document review on 05/23/2023 at 2:35 PM revealed that the 4th quarter water flow inspection had been delayed from December to January. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 353	K 353 Sprinkler system Maintenance Corrective Action The quarterly water flow inspection was conducted on 6/15/23. Closet storage has been adjusted to so that there is no storage within 18 inches of the sprinkler head on 6/16/23. A line of tape was placed in the closet to identify the 18-inch mark. Identification of Others Residents have the potential to be affected by the water flow inspection. An audit was conducted of resident	

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K 353	Continued From page 17 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.1.1.2, Table 5.1.1.2 2. Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency was present throughout the facility. The findings were: Observation on 05/23/2023 at 11:19 AM the closet of room 301 revealed there was storage stacked within the 18" height clearance to the sprinkler head, which results in an obstruction to the dispersion pattern of the affected sprinkler. Further observation found this to be a common observation with most of the closets on the third floor, and with several closets on the second floor. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 353	closets on 6/16/23 to validate there was no storage within 18 inches of the sprinkler head. Any closet identified as a concern had storage adjusted to meet the requirement. Systemic Change In-service training was provided to the Maintenance staff related to the 6-month requirement for the water flow inspection on 6/16/23 by the Executive Director. The Maintenance Director/designee monitors the water flow inspection records monthly to validate the inspection does not exceed the 6-month requirement. In-service education was provided to the staff on 5/31/23 regarding to not having closet storage within 18 inches of the sprinkler heads. The Maintenance Director/designee audits resident closets monthly to validate that no storage is within 18 inches of the sprinkler head. If identified, items are adjusted. Monitoring The Maintenance Director brings the results of the of the water flow inspection and closet storage audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued	

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K 353	Continued From page 18	K 353	at that time unless the QAPI Committee deems it prudent to continue.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain elevator machine rooms in accordance with the 2012 NFPA 101, Life Safety Code and the ASME Safety Code for Existing Elevators and Escalators. The failure to maintain elevator machine rooms as required could result in injury or death due ton in increased risk of fire, or a loss of egress systems during an emergency. The deficiency affected one (1) of one (1) elevator machine rooms in the facility. The findings were:	K 531	K 531 Elevators Corrective Action The Maintenance staff removed the storage from the elevator room on 5/24/23. Identification of Others Residents have the potential to affected	6/23/23

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K 531	Continued From page 19 Observation on 05/23/2023 at 8:24 AM in the elevator machine room revealed a large amount of storage in the room. 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 19.5.3, 9.4.2.2 2008 ASME A17.3-2008, Sections Part IV Section 4.1, Part II Section 2.2.1	K 531	by this practice. The facility only has 1 elevator room. Systemic Change The Maintenance staff received in-service education on 6/16/23 related to not storing items in the Elevator room from the Executive Director. Monthly the Maintenance Director/designee inspects the elevator room for storage. If any items are found they are removed. Monitoring The Maintenance Director brings the results of the of the elevator room audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue	
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		6/23/23

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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 05/23/2023 at 9:15 AM in the admissions office revealed a portable space heater. The area is a non-sleeping staff area, however it was not possible determine the maximum temperature of the heating elements. Portable space heating elements shall be limited to a maximum temperature of 212 degrees Fahrenheit. 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 19.7.8	K 781	K 781 Portable Space heaters Corrective Action The portable space heater was removed on 5/25/23. Identification of Others The Maintenance staff conduced an audit of the facility on 5/24/23 and no portable space heater were found. Systemic Change The staff was provided in-service education related to not having portable space heaters in the facility on 5/31/23. The Maintenance Director/designee audits the facility monthly for portable space heaters. If any are found they are removed. . Monitoring The Maintenance Director brings the results of the of the portable space heater audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		6/23/23

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K 918	Continued From page 21 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to exercise the generator in	K 918	K 918 Electrical systems	

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K 918	Continued From page 22 accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to exercise the generator could result in the generator not functioning during an emergency. The deficiency affected the generator and life safety systems of the facility. The findings were: Document review on 05/23/2023 at 2:50 PM revealed that generator load testing had been performed, but had only ran for 0.3 hours once a month. Diesel generators shall be exercised monthly for 30 minutes. 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 110, Sections: 8.4.2, 8.4.2.3	K 918	Corrective Action On 6/19/23 the emergency generator was exercised under load for 30 minutes by the Maintenance Director. Identification of Others Residents have a potential to be affected by this practice. The facility only has 1 emergency generator. Systemic Change In-service education was provided to the Maintenance staff related to the 30-minute generator exercise on 6/16/23. The Maintenance Director monitors the 30-minute generator exercise monthly to validate that the it runs for the required 30 minutes and that the test is recorded. Monitoring The Maintenance Director brings the results of the of the emergency generator monthly exercise audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		6/23/23

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GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 920	Continued From page 23 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 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 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 to an increased risk of fire. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 05/23/2023 at 2:18 PM in room 211 revealed that a surge protector was plugged into a surge protector, creating a daisy chain.	K 920	K 920 Power cords Corrective Action The Maintenance Director removed the one surge protector that was plugged into the second surge protector 5/23/23. Identification of Others The Maintenance Director conducted an audit of the facility on 5/24/23 to make sure there were no more daisy chains in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**05/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 24 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 9.1.2 2011 NFPA 70, Section 400.8	K 920	the facility. None were found. Systemic Change The staff was provided in-service education related to not plugging surge protectors into other surge protectors on 5/31/23. The Maintenance Director/designee conducts monthly rounds within the facility to identify any Daisy Chains. If any are found it is corrected immediately. Monitoring The Maintenance Director brings the results of the of the Daisy Chain audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue monthly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue	