STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**06/21/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 06/15/2023. 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		7/17/23

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

Electronically Signed | 07/17/2023

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 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 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. Failure to maintain a reliable fuel source for the emergency generator could result in a failure of the emergency electrical system, resulting in injury or death. 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	E 041	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	

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E 041	Continued From page 3 the facility administrator revealed that no letter from the natural gas provider was available to provide proof of low probability of interruption and demonstrated reliability. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, 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	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. E041 LTC Emergency Power I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 7/17/2023 the administrator obtained a letter of reliability from the power company (Black Hills Energy) dated on June 30, 2022 indicating the standards for emergency and standby power systems were in compliance with Life Safety Codes. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency due to an emergency if Gas is shut off. On 7/17/23 the maintenance director and administrator reviewed the letter of	

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E 041	Continued From page 4	E 041	reliability from the power company to determine the standards for emergency power were in compliance with Life Safety Codes, and that concerns have been corrected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and maintenance team were educated by the NHA on 6/22/23 about the deficiency and requirement to maintain a letter of reliability for emergency and standby power in accordance with the Life Safety Code. Maintenance Team will be responsible for maintaining a current letter of reliability from the power company and reporting any lapse in reliability to the NHA. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved.	

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E 041	Continued From page 5	E 041	Date of Compliance: 7/17/23	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 06/21/2023. 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 (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with an wet antifreeze sprinkler system, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 71 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324		7/14/23

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K 324	Continued From page 6 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking equipment in 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 06/21/2023 at 1:41 PM 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,	K 324	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 324	Continued From page 7 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 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K 324	K324 Cooking Facilities I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 7/14/23 in the kitchen, the wheeled gas-fired cooktop located beneath the grease hood and fire suppression system was properly positioned and clearly marked on the floor to indicated approved location after service or cleaning. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency if a fire is started in kitchen and suppression does not cover the appropriate area. By 7/14/23 the maintenance director ensured proper positioning and clearly marked the approved location of the cooktop to properly protect the cooking equipment. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 6/22/23 the maintenance director and	

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K 324	Continued From page 8	K 324	maintenance team were educated by the NHA about the deficiency and requirement. Maintenance Team will be responsible for monitoring facility's cooking equipment and ensuring all cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations to meet the Life Safety Code requirement. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will audit cooking equipment in the facility weekly X 4 weeks, then monthly X 2 months ensuring all cooking equipment is within the Life Safety Code standard for ventilation control and fire protection. Any identified concerns will be corrected immediately. The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 7/14/23	
K 351 SS=D	Sprinkler System - Installation	K 351		7/14/23

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K 351	Continued From page 9 CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death in the event of a fire. The deficiency affected two of numerous storage areas throughout the facility. The findings were: Observation on 06/21/2023 at 10:17 AM at the storage room by the exit near laundry and on the way to oxygen storage revealed that boxes of soap dispensers were stacked within several inches of the sprinkler head, which resulted in an	K 351	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED 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	

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K 351	Continued From page 10 obstruction to the dispersion pattern of the affected sprinkler. Observation on 06/21/2023 at 11:40 AM revealed the storage in the activities office stacked within several inches of the sprinkler head, which resulted in an obstruction to the dispersion pattern of the affected sprinkler. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 351	PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. K351 Sprinkler System - Installation I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/22/23 the storage room by the exit near laundry and the way to oxygen storage, and the storage in the activity's office were cleared of storage which obstructed the sprinkler heads from normal dispersion patterns. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency if a fire occurs and the sprinkler system does not disperse accordingly can cause fire to spread. By 7/14/23 the Maintenance Director audited all facility storage areas with sprinkler heads to ensure no obstructions were present, and that all standards for	

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K 351	Continued From page 11	K 351	the inspection, testing and maintenance of water based fire protection systems were in compliance with the Life Safety Code. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and the maintenance team were educated on 6/22/23 by the NHA about the deficiency and requirement. Maintenance Team will be responsible for monitoring the facility's fire suppression systems to ensure all sprinkler heads are free from obstructions. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will audit the facility's fire suppression systems, with a special focus on storage areas, weekly X 4 weeks, then monthly X 2 months, ensuring all sprinkler heads are free from obstruction in the facility per Life Safety Code requirements. Any identified concerns will be corrected immediately. The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 12	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was throughout the above ceiling areas. The findings were: Observation on 06/21/2023 starting at 9:51 AM in	K 353	Date of Compliance: 7/14/23 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	7/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**06/21/2023**

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

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K 353	Continued From page 13 the above ceiling corridor area, by room 123, revealed that communication wires were draped across the sprinkler pipeline. Further observations found communication wires, flex ducting, electrical wires, and roof insulation on the sprinkler pipeline at attic access hatch locations throughout the building. 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 19.3.5.1, 9.7.5 2011 NFPA 25, Section: 5.2.2.2 2. Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was in two (2) rooms out of numerous rooms in the facility. The findings were: Observation on 6/21/2023 at 10:39 AM in the closet of room 132, revealed a fire sprinkler head with escutcheon that had shifted from its initial position, exposing the annular space. Escutcheons shall be used to cover the annular space around the sprinkler head. Further observation on 06/21/2023 at 12:00 PM found that in room 147 the sprinkler escutcheon had become lose exposing the annular space above the ceiling.	K 353	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. K353 Sprinkler System Maintenance and Testing I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: By 7/14/23 sprinkler pipeline above the ceiling corridor area, by room 123, was cleared of all communication wires, flex ducting, electrical wires, and roof insulation. Facility took proper steps to suspend wires off all pipes and remove insulation or duct work touching pipes. Also by 7/14/23 rooms 132 and 147 had their sprinklers adjusted and escutcheon replaced or repaired to cover exposed space. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors have the	

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K 353	Continued From page 14 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 353	potential to be affected by this alleged deficiency if too much weight is applied to the sprinkler system causing failure. Fire can spread through any spacing in the ceiling which could lead to a spread throughout the ceiling space. By 7/14/23 the maintenance director conducted observations of the above ceiling corridor areas for the facility to ensure all sprinkler pipelines were free of communication wires, flex ducting, electrical wires, and roof insulation or other debris. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and the maintenance team were educated on 6/22/23 by the NHA about the deficiency and requirement. Maintenance Team will be responsible to ensure sprinkler pipelines are not covered or draped with inappropriate materials in the above ceiling corridor of the facility. They will also be responsible to ensure that all escutcheons will be fitted appropriately. WIll also ensure that Sprinklers are appropriately fitted for spacing between the ceiling and sprinkelr heads.	

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K 353	Continued From page 15	K 353	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will audit the above ceiling corridor of the facility weekly X 4 weeks, then monthly going forward to ensure that sprinkler pipelines are not covered or draped with inappropriate materials. Furthermore, the Maintenance Director shall approve any maintenance plans for the above ceiling corridor to ensure no new debris is to be draped over the sprinkler pipelines, and all future work will be inspected by the Maintenance Director prior to the completion of the work. Any identified concerns will be corrected immediately. The Maintenance Director will audit the escutcheons of the facility weekly X 4 weeks, then monthly going forward to ensure that sprinkler pipelines are not covered or draped with inappropriate materials. The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 7/14/23	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		7/14/23

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K 511	Continued From page 16 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. The findings were: Observation on 06/21/2023 at 9:03 AM at the south east exit revealed an electrical outlet without a cover above the door. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 406.6 2. Based on observation and staff interview, the	K 511	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. K511 Utilities – Gas and Electric	

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K 511	Continued From page 17 facility failed to provide a junction box cover in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 70, National Electric Code. Failure to provide a junction box cover could result in damage to the electrical system, resulting in injury or death. The deficiency was at one (1) of many exit doors. The findings were: Observation on 06/21/2023 at 10:26 AM in the space above main entrance, it was observed that a junction box on the ceiling of the boiler room, was uncovered. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1.1, 9.1.2 2011 NFPA 70, Section: 314.25	K 511	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/22/23 the electrical outlet at the south east exit, and the junction box in the space above the main entrance were covered with appropriate fixtures. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency if a resident inserted an appendage or metal object into the outlet. By 7/13/23 all electrical outlets, switches, and junction boxes were inspected in the facility and were inspected by the maintenance team to ensure regulations were met for this requirement. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and the maintenance team were educated on 6/22/23 by the NHA about the deficiency and requirement.	

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K 511	Continued From page 18	K 511	Maintenance Team shall be responsible to ensure that all electrical fixtures in the facility maintain compliance with the Life Safety Code regulation. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will audit all facility's electrical fixtures weekly X 4 weeks, then monthly X 2 months. Any identified concerns will be corrected immediately. Furthermore, the Maintenance Director shall approve any maintenance plans for electric fixtures to ensure all future work meets the Life Safety Code regulations, and this work will be inspected by the Maintenance Director prior to the completion of the project. The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 7/14/23	
K 911 SS=D	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	K 911		7/17/23

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K 911	Continued From page 19 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. Failure to maintain a reliable fuel source for the emergency generator could result in a failure of the emergency electrical system, resulting in injury or death. The deficiency affected one (1) of one (1) generator for the facility. The findings were: Document review on 06/21/2023 at 2:30 PM with the facility administrator revealed that no letter from the natural gas provider was available to provide proof of low probability of interruption and demonstrated reliability. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, 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	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. K911 Electrical Systems - Other I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 7/17/2023 the administrator obtained a letter of reliability from the power company	

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K 911	Continued From page 20	K 911	(Black Hills Energy) dated June 30, 2022 meeting the standards for emergency and standby power systems were in compliance with Life Safety Codes. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency due to an emergency if electricity is shut off. On 7/17/23 the maintenance director and administrator reviewed the letter of reliability from the power company to determine the standards for emergency power were in compliance with Life Safety Codes, and that concerns have been corrected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and maintenance team were educated by the NHA on 6/22/23 about the deficiency and requirement to maintain a letter of reliability for emergency and standby power in accordance with the Life Safety Code. Maintenance Team will be responsible for maintaining a current letter of reliability	

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K 911	Continued From page 21	K 911	from the power company and reporting any lapse in reliability to the NHA. Any identified concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 7/17/23	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The failure to maintain electrical systems as required could result in a failure of the	K 919	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	7/14/23

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K 919	Continued From page 22 electrical system, resulting in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 06/21/2023 at 9:33 AM in Rehab revealed multiple obstructions in front of the electrical panel. A working space of three (3) feet in front of the panels is to be maintained. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	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. K919 Electrical Equipment - Other I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/22/23 the obstructions in front of the electrical panel in Rehab were removed and have been stored in the appropriate area. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified in this deficient practice. All residents, staff and visitors have the potential to be affected by this alleged deficiency if an emergency	

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K 919	Continued From page 23	K 919	happened and unable to access panel. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director and team were educated on 6/22/23 by the NHA about the deficiency and requirement. Maintenance Team is responsible for compliance with the requirement for maintaining electrical systems in accordance Life Safety Code. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will audit the facility's electrical systems to ensure they are free from obstructions weekly X 4 weeks, then monthly X 2 months to ensure a working space of three (3) feet in front of the panels is maintained in the facility. Any identified concerns will be corrected immediately. The Maintenance Director will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved.	

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K 919	Continued From page 24	K 919	Date of Compliance: 7/14/23	