STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING **01** B. WING _____	**07/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	**707 SHERIDAN AVENUE** **CODY, WY 82414**

(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 07/12/2023. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/12/2023. Requirements for Long Term Care Facilities, Section 42 CFR 483.90 except as otherwise provided in this 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, two-story building of Type II (III) construction built in 1982 and renovated in 1992 with an addition in 2010. The building was equipped with a supervised, automatic wet sprinkler system and a dry branch, with an addressable fire alarm system. The facility had a capacity of 94 certified Medicare and Medicaid beds with a census of 51 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=E	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	K 100		8/4/23

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

Electronically Signed | 08/01/2023

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K 100	Continued From page 1 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 fire-resistive construction in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain fire-resistive construction could result in the spread of fire and smoke, which could result in injury or death. The deficiency affected one (1) mechanical penthouse and had the potential to affect all residents, staff, and visitors. The findings were: Observation on 07/12/2023 at 10:40 AM revealed that the facility failed to maintain ceiling fire-resistive construction. Observation of the second floor EVS room, adjacent to resident room 211, revealed that the room contained a ladder and access hatch to a mechanical penthouse. Observation of the access hatch revealed that it was left open so the 1-hour fire resistant ceiling assembly was not being maintained. Observation and document review revealed that the facility construction type is Type II (111) so the ceiling assembly is required to be maintained as 1-hour fire resistant. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.1.1.1.3, 4.6.13.1	K 100	K 100 1. No residents were identified as being affected. 2. All residents have the potential to be affected by the hatch not being closed properly. The door was shut and secured immediately. Parts have been ordered for repair of the door and it is remaining secured shut in the meantime. 3. All plant ops staff were in-serviced on ensuring the EVS hatch door is kept closed. 4. For the next 60 days, the Director of Plant Ops or his designee will conduct weekly audits of hatch doors to ensure compliance with keeping them closed properly. 5. The Director of Plant Ops or his designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	

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K 291	Continued From page 2	K 291		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain emergency lighting could result in a failure of the emergency lighting, which could lead to a delay of egress in an emergency, resulting in injury or death. The deficiency affected all emergency battery powered lighting and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/12/2023 starting at 11:10 AM revealed that the facility failed to properly test emergency battery powered lighting. At the time of the survey no documentation was available to demonstrate that the monthly 30 second testing of emergency battery powered lighting was being conducted. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1	K 291	K291 1. No residents were identified as being affected. 2. All residents have the potential to be affected by ensuring monthly testing of emergency lighting is conducted. 3. All plant ops staff were in-serviced on ensuring emergency lighting is tested monthly and properly documented. 4. For the next 60 days, the Director of Plant Ops or his designee will conduct audits of testing to ensure compliance with monthly testing of the emergency lighting. 5. The Director of Plant Ops or his designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	8/4/23

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K 321 SS=E	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 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 protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in the spread of fire and smoke, which could result in injury or death. The	K 321	K 321 1. No residents were identified as being affected. 2. All residents have the potential to be affected by the activity closet door not	8/4/23

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K 321	Continued From page 4 deficiency affected one (1) hazardous room and had the potential to affect all residents, staff, and visitors. The findings were: Observation on 07/12/2023 at 10:10 AM revealed that the facility failed to maintain doors to hazardous areas. Observation of Activity Storage room revealed that the room contained a large amount of combustible storage and opened directly to the corridor. The door to the room was equipped with a self-closing device that, when released from its fully open position, would not completely close and latch. Doors protecting hazardous areas shall be self-closing or automatic-closing. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.1.3	K 321	closing properly. Other doors were checked for proper closing. The activity closet door was repaired and is closing properly. 3. All plant ops staff were in-serviced on the requirement of proper functioning of door closures. 4. For the next 60 days, the Director of Plant Ops or his designee will conduct weekly audits of of the activity closet door to ensure continued compliance with the door closure. 5. The Director of Plant Ops or his designee will report results of audits to the QAPI committee monthly for the next 60 days. Additional training and/or audits will be completed as appropriate to ensure ongoing compliance.	