STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01, 02** B. WING _____	**08/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

(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 08/09/2023. 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 08/08/2023 and 08/09/2023. Requirements for Long Term Care Facilities Section 42 CFR 483.90(a) 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 (west and central wings) was a fully sprinklered one story building with a partial basement of Type V (000) and Type V (111) construction built in 1958 and 1987. The building was equipped with a supervised wet sprinkler system (west wing) and a dry sprinkler system (Central wing), and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 152 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 08/08/2023 and 08/09/2023.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2023

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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K 000	Continued From page 1 Requirements for Long Term Care Facilities Section 42 CFR 483.90(a) 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 (east wing) was a fully sprinklered one story building of Type II (111) construction built in 1979. The building was equipped with a supervised wet sprinkler system (east wing) and an addressable fire alarm system. The facility had 192 certified Medicare and Medicaid beds with a census of 152 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 100 SS=D	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 accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms. The findings were: Observation on 08/08/2023 at 3:13 PM in the director of dietary office found a ceiling tile missing.	K 100	1)Missing ceiling tile was immediately replaced. 2)Audit performed by AED and Maintenance Department on 8/9/23 to ensure all ceiling tiles were intact. Any needed corrections were done at that time. 3)Staff educated on ensuring ceiling tiles are in place and to let a member of maintenance know if one is missing. 4)Maintenance Director/Designee will	9/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING **01, 02** B. WING _____	**08/09/2023**

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SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

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K 100	Continued From page 2 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	audit the facility weekly for four weeks then monthly for 2 months to ensure there are no missing ceiling tiles. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 222 SS=F	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 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	K 222		9/4/23

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K 222	Continued From page 3 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 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: 1. 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 delay egress from the building	K 222	1)The egress doors observed by the surveyor have been corrected to ensure code is labeled on the door so staff are aware of egress. Door that was locked, is now unlocked and will remain so. Sign on	

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K 222	Continued From page 4 during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation and interview on 8/09/2023 at 9:17 AM at the north-east exit door from the secured unit found that the door was equipped with a number pad to unlock the door. No staff in the area were able to demonstrate immediate knowledge of the code necessary for egress to the surveyor. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4) 2. 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 delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation on 08/09/2023 at 10:37 AM at the exit door for the east rapid recovery revealed that when tested the door appeared to be locked. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the	K 222	door indicates that door will remain unlocked at all times. 2)Entry doors within facility were audited to ensure compliance, by maintenance director on 8/10/23. 3)Staff were educated on the expectations of egress door policies to be followed and to notify maintenance should they observe this with any doors moving forward, or if they are unaware of the code to exit the door. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure compliance with egress doors. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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K 222	Continued From page 5 requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5.1, 7.2.1.5.3	K 222		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing as required could result in injury or death during an emergency. The deficiency affected numerous doors with self-closing devices throughout the facility. The findings were: Observation starting on 08/08/2023 at 2:34 PM at the laundry south by nursing unit revealed the	K 223	1)Doors that wouldn't latch were immediately corrected. Facility wide audit was conducted to ensure no other doors were having any issues with not closing completely. 2)Audit performed by AED and Maintenance Department on 8/10/23 to ensure all doors in facility were latching upon closure. Any needed corrections were done at that time. 3)Staff educated on ensuring doors latch	9/4/23

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K 223	Continued From page 6 self-closing door failed to operate as designed. When dropped tested with no initial motion the door failed to shut and latch. Further observation throughout the survey revealed numerous additional self-closing doors that would not latch when dropped from the open position. Interview with the facility maintenance manager at the time of the 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, 7.2.1.8	K 223	and to notify maintenance right away if they were not. 4)Maintenance Director/Designee will audit random doors weekly for four weeks then monthly for 2 months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 223	1)Doors that wouldn't latch were	9/4/23

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K 223	Continued From page 7 facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing as required could result in injury or death during an emergency. The deficiency affected numerous doors with self-closing devices throughout the facility. The findings were: Observation starting on 08/08/2023 at 2:34 PM at the soiled utility room by room 120 revealed the self-closing door failed to operate as designed. When dropped tested with no initial motion the door failed to shut and latch. Further observation throughout the survey revealed numerous additional self-closing doors that would not latch when dropped from the open position. Interview with the facility maintenance manager at the time of the 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, 7.2.1.8	K 223	immediately corrected. Facility wide audit was conducted to ensure no other doors were having any issues with not closing completely. 2)Audit performed by AED and Maintenance Department on 8/10/23 to ensure all doors in facility were latching upon closure. Any needed corrections were done at that time. 3)Staff educated on ensuring doors latch and to notify maintenance right away if they were not. 4)Maintenance Director/Designee will audit random doors weekly for four weeks then monthly for 2 months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit	K 293		9/4/23

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K 293	Continued From page 8 travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous areas in the facility. The findings were: Observation on 8/8/2023 at 2:08 PM in the south dining room looking north towards the rest of the facility revealed that no exit sign could be observed except by reflection off a mirror. Interview with the facility 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: 19.2.10.1; 7.10.1.1, 7.10.1.5.1	K 293	1)Exit sign was ordered and placed above exit doorway from South Dining Room. 2)Audit performed by AED and Maintenance Department on 8/10/23 to ensure all needed exit signs were available and visible. Any needed corrections were done at that time. 3)Staff educated on ensuring exit signs were hung and visible per regulation. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate exit signs and signage according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		9/4/23

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K 345	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system as required could result in injury or death in the event of a fire. The deficiency could impact all staff, residents, and visitors throughout the facility. The findings were: Document review on 08/09/2023 starting at 11:00 AM revealed that no records of annual fire alarm system testing and inspection were available for the surveyor's review. The facility stated that an annual inspection was conducted in July of 2023, but that paper work had not yet been received. The previous annual fire alarm system testing and inspection that the facility had documentation for was from January of 2022. 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: 2010 NFPA 72 Table 14.4.5(1), Table 14.3.1(3)(d), Table 14.4.5(20), 14.6.2.4, Table 14.4.5(15)(f), Table 14.4.5(15)(e), Table 14.4.5(15)(h), Table 14.4.5(15)(i) 2012 NFPA 90A Section 4.4.1	K 345	1)Fire Alarm System was tested and documentation was provided by company. 2)Audit performed by AED and Maintenance Department on 8/10/23 to mandatory testing occurred according to compliance and regulation. Any needed corrections were done at that time. 3)Staff educated on fire alarm systems are tested per regulation. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		9/4/23

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K 345	Continued From page 10 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency could impact all staff, residents, and visitors throughout the facility. The findings were: Document review on 08/09/2023 starting at 11:00 AM revealed that no records of annual fire alarm system testing and inspection were available for the surveyor's review. The facility stated that an annual inspection was conducted in July of 2023, but that paper work had not yet been received. The previous annual fire alarm system testing and inspection that the facility had documentation for was from January of 2022. 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: 2010 NFPA 72 Table 14.4.5(1), Table 14.3.1(3)(d), Table 14.4.5(20), 14.6.2.4, Table	K 345	1)Fire Alarm System was tested and documentation was provided by company. 2)Audit performed by AED and Maintenance Department on 8/10/23 to mandatory testing occurred according to compliance and regulation. Any needed corrections were done at that time. 3)Staff educated on fire alarm systems are tested per regulation. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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K 345	Continued From page 11 14.4.5(15)(f), Table 14.4.5(15)(e), Table 14.4.5(15)(h), Table 14.4.5(15)(i) 2012 NFPA 90A Section 4.4.1	K 345		
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 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 install sprinklers in all required areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to the install sprinklers in all required areas could result in injury or death in the event of a fire. The deficiency affected one of numerous smoke compartments. The findings were: Observation on 08/08/2023 at 3:10 PM in the boiler room revealed the rear storage closet was	K 351	1)The observed sprinklers were corrected to meet compliance with Escutcheons and hanging bracket. The storage on the unit storage unit was corrected to meet regulations and compliance. 2)An audit was conducted to inspect facility sprinklers in the building, by maintenance director on 8/10/23. An audit was conducted to inspect storage and regulations with storage. Any needed	9/4/23

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	535042	A. BUILDING **01, 02** B. WING _____	**08/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA** **CASPER, WY 82604**

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K 351	Continued From page 12 not provided with sprinkler protection as required. Interview with the maintenance manager at the time of observations 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 13, Sections: 19.3.5.1 2. Based on observation and staff interview, the facility failed to 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 impacted isolated areas in numerous smoke compartments throughout the facility. The findings were: Observation on 08/09/2023 at 9:45 AM in room 67 revealed a fire sprinkler head with the escutcheon missing, exposing the annular space. Additional observation on 08/09/2023 at 10:12 AM in the basement by office storage revealed a missing escutcheon, exposing the annular space. Interview with the maintenance manager at the time of observations acknowledged the deficiency, and indicated awareness 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	corrections were done at that time. 3)Staff were educated on the expectations of storage and sprinkler systems ensuring policies are followed and to notify maintenance should they observe this with any storage space or sprinkler moving forward. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure compliance with sprinkler systems. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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K 351	Continued From page 13	K 351		
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 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 during an emergency. The deficiency affected two (2) of numerous rooms throughout the facility. The findings were: Observation on 08/08/2023 at 4:05 PM in the storage room by room 107 revealed objects stacked close to the ceiling within several inches of the sprinkler head. Additional observation on	K 351	1)The observed storage on the top shelf was corrected to meet regulations and compliance. 2)An audit was conducted to inspect facility sprinklers in the building, by maintenance director on 8/10/23. An audit was conducted to inspect storage and regulations with storage. Any needed corrections were done at that time. 3)Staff were educated on the expectations of storage and sprinkler systems ensuring policies are followed and to notify maintenance should they observe this with any storage space or sprinkler moving forward.	9/4/23

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K 351	Continued From page 14 08/08/2023 at 4:35 PM in room 119 closet found objects stacked close to the ceiling, and obstructing the sprinkler head. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 351	4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure compliance with sprinkler systems. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 353 SS=D	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	K 353		9/4/23

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K 353	Continued From page 15 by: Based on observation and staff interview, the facility failed to to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous areas throughout the facility. The finding was: Observation on 08/09/2023 at 10:13 AM in basement entrance to the boiler room revealed a fire sprinkler head down from the ceiling exposing the annular space. When an attempt was made by the maintenance manager to get it back into place it was observed to immediately fall away from the ceiling again indicating the sprinkler hanger to be damaged or loose. Interview with the maintenance manager at the time of observations acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2011 NFPA 25, Sections: 5.2.3.1	K 353	1)Sprinkler System was tested and documentation was provided by company. 2)Audit performed by AED and Maintenance Department on 8/10/23 to mandatory testing occurred according to compliance and regulation. Any needed corrections were done at that time. 3)Staff educated on sprinkler systems are tested per regulation. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are appropriate testing according to regulation. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	
K 906 SS=D	Gas and Vacuum Piped Systems - Central Supply CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No	K 906		9/4/23

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K 906	Continued From page 16 flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiency affected one (1) of one (1) oxygen storage rooms in the facility. The findings were: Observation on 08/08/2023 in 2:45 PM at the oxygen room revealed oxygen concentrators stored with oxygen cylinders. Oxygen concentrators are constructed of combustible materials, and may not be stored within oxygen cylinder storage areas. Interview with the maintenance manager at the time of observation acknowledged the deficiency,	K 906	1)Oxygen concentrators were immediately removed and put in secure storage, outside of the oxygen fill room. 2)Audit performed by AED and Maintenance Department on 8/9/23 to ensure all oxygen tanks were secure in secure oxygen storage. Any needed corrections were done at that time. 3)Staff educated on ensuring oxygen tanks are kept in secure storage when not in use and not kept in the oxygen fill room. 4)Maintenance Director/Designee will audit the facility weekly for four weeks then monthly for 2 months to ensure there are no oxygen tanks left out of secure storage when not in use. Results of initial as well as ongoing audits will be reviewed	

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K 906	Continued From page 17 and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99, Section 5.1.3.2.3	K 906	via the monthly QAPI process with recommendations made as necessary.	