STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING **01** B. WING _____	**10/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE** **SHERIDAN, WY 82801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 10/03/2023. 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 10/03/2023. 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, single story building of Type V (111), with a basement, built in 1962 and 1988. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 76 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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	K 321		10/27/23

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

Electronically Signed | 10/26/2023

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K 321	Continued From page 1 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, resulting in injury or death. The deficiency affected one (1) hazardous room and has the potential to affect all residents, staff, and visitors within the observation area. The findings were: Observation on 10/03/2023 at 12:25 PM revealed the facility failed to protect hazardous areas. Observation of a corridor closet located in the	K 321	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A commercial grade door closer was installed on the door to the soiled utility closet in the secured unit. This mechanism allows for the door to self-close completely. The soiled items will be safely secured inside the closet. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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K 321	Continued From page 2 secured unit revealed that the closet was being utilized as a soiled holding room. The closet door was not equipped with an automatic door closer. 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	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficiency. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The Maintenance Director/designee will audit all soiled utility locations to ensure that each door is working correctly. The audit will be conducted weekly for 4 weeks then monthly for 2 months. All audits will be recorded on TELS. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Date of Compliance 10/27/2023	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101	K 324		10/27/23

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K 324	Continued From page 3 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 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the kitchen hood in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly test and maintain the kitchen hood could result in a malfunction or failure of hood, resulting in injury or death in the event of a fire. The deficiency affected the kitchen and could potential	K 324	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen hood was inspected on October 19, 2023 by a third-party contractor. This inspection tests for proper ventilation and fire protection.	

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K 324	Continued From page 4 to affect all staff and visitors in the area. The findings were: Document review on 10/03/23 starting at 1:25 PM revealed the facility failed to conduct the required inspection and testing of the kitchen hood. No documentation was available at the time of the survey to demonstrate that the kitchen hood ansul system had been inspected and tested twice in the last twelve (12) months. Documentation was available to show that the kitchen hood ansul system was tested in January of 2023. Additionally, documentation was not available at the time of the survey to demonstrate that the kitchen hood had been inspected for cleaning twice in the last twelve (12) months. Documentation was available at the time to demonstrate that the kitchen hood was inspected for cleaning in May of 2023. 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 the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.4, 11.5	K 324	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: All hood inspections and cleanings will be on a six-month schedule. Hood related tasks will be uploaded to TELS. These tasks will be on a six-month rotation. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will audit hood inspections bi-annually x 2 inspections. All audits will be documented and made available to the QAPI Committee. All services will be scheduled a month prior to the inspection deadline. Date of Compliance 10/27/2023	
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	K 345		10/27/23

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K 345	Continued From page 5 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 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 10/03/2023 starting at 1:25 PM revealed the facility failed to conduct semi-annual and annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the inspection and load voltage testing of the fire alarm system batteries was conducted twice in the last twelve (12)months. Documentation review revealed that the annual testing of the fire alarm notification devices was conducted, however, the notification devices were not identified with a location description. Fire alarm system batteries shall be inspected and tested semi-annually, and fire alarm notification devices shall be identified individually with a location description and pass/fail checkoff for each device.	K 345	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All batteries connected to the fire alarm system have been load tested on October 21, 2023. This test needs to be performed to guarantee that the fire alarm system will continue to operate during an outage. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this deficiency. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: All batteries will continue to be tested with a voltage meter. Battery voltage for the fire alarm system will be logged on to TELS monthly for 12 months. Each log will include the battery identification, the date tested, and the voltage of each battery. Third-party inspections of the fire	

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K 345	Continued From page 6 Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d), Table14.4.5(6)(3), Table 14.4.5(20), 14.6.2.4	K 345	alarm system will continue on a 6-month rotation. V. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will report any deficiencies to the QAPI committee. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Date of Compliance 10/27/2023	
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	K 353		10/27/23

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K 353	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in a malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 10/03/2023 starting at 1:25 PM revealed the facility failed to perform all required testing of the fire sprinkler system. No documentation was available at the time of the survey to demonstrate that the annual testing of the main drain, back flow preventer, or partial trip of the dry system had been conducted in the last twelve (12) months. No documentation was available at the time of the survey to demonstrate that the full flow trip test of the dry system had been conducted in the last three (3) years. 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 the exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.2.5, 13.6.2.1, 13.4.4.2.4, 13.4.4.2.2.2	K 353	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Sprinkler suppression system documentation was not provided at the time of the survey. All documentation has been filed and made available to all staff. The next back-flow inspection is scheduled for October 27th, 2023. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: All future inspections will be coordinated with the suppression system inspector. TELS tasks will be updated in accordance with the scheduling. All suppression related documentation will be logged on TELS. V. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:	

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K 353	Continued From page 8	K 353	Tels task has been scheduled for sprinkler system and backflow testing. On a quarterly basis. Monitoring will be completed via Tels alerts. All documentation will be available to the QAPI committee. The committee will review all deficiencies that are listed in the documentation. Further actions will be taken regarding any deficiencies. Date of Compliance 10/27/2023	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire dampers could result in a malfunction or failure of the dameprs, resulting in injury or death in the event of a fire. The deficiency affected the HVAC system and could potential to affect all residents, staff, and visitors.	K 521	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All fire/smoke dampers have been inspected on October 23, 2023, by the Maintenance Director. The inspection was completed in a safe manner. There were no obstructions found.	10/27/23

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K 521	Continued From page 9 The findings were: Document review on 10/03/23 starting at 1:25 PM revealed that the facility failed to conduct the required inspection and testing of the fire dampers. No documentation was available at the time of the survey to demonstrate that the fire dampers had been tested and inspected in the last four (4) years. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.5.2.1, 9.2.1 2012 NFPA 90A 5.4.8; 2010 NFPA 80 19.4.1	K 521	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: TELS has been updated for the fire damper inspection to reoccur every 48 months. All fire damper inspections will be recorded on the TELS program. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director will monitor all tasks on TELS. All fire damper related tasks will not be completed until logged. Date of Compliance 10/27/2023	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		10/27/23

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K 761	Continued From page 10 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain egress doors and fire rated doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain egress doors and fire rated doors could result in a delay or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all egress and fire rated doors, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 10/03/23 starting at 1:25 PM revealed the facility failed to conduct the annual inspection and testing of egress and fire rated doors. No documentation was available at the time of the survey to demonstrate that the annual inspection of door assemblies that swing in the direction of egress travel, or fire rated door assemblies, had been completed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated that they were aware of the	K 761	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Inspection of the egress and fire rated doors was completed on October 5th, 2023. The inspection was completed by the Maintenance Director, who has a fire protection certification. The inspection includes the location of each door, the identification number of the door, a pass or fail status, and any comments related to the doors. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	

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K 761	Continued From page 11 requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	OCCUR AGAIN: The Maintenance Director will continue to complete monthly audits on the fire-rated doors. All documentation will be recorded on TELS. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: All documentation will be available to the QAPI committee. All deficiencies will be recorded and reviewed by the committee. Date of Compliance 10/27/2023	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914		10/27/23

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	535026	A. BUILDING **01** B. WING _____	**10/03/2023**

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K 914	Continued From page 12 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain non-hospital grade receptacles in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain non-hospital grade receptacles could result in a failure or malfunction of the receptacles, resulting in injury or death. The deficiency affected all non-hospital grade receptacles in patient care areas and has the potential to affect all residents, staff, and visitors in those spaces. The findings were: Document review on 10/03/23 starting at 1:25 PM revealed the facility failed to conduct the annual inspection and testing of non-hospital grade receptacles in patient care areas. No documentation was available at the time of the survey to demonstrate that the annual inspection and testing of the non-hospital grade receptacles in patient care areas had been completed in the last twelve (12) months. 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 the exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.3.4.1, 6.3.3.2	K 914	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residential rooms were tested for functioning non-hospital grade receptacles on October 5, 2023. This needs to be addressed annually for resident safety. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by this alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: TELS has been updated to have the receptacles inspected annually. The task will be monitored and not completed without a log. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:	

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K 914	Continued From page 13	K 914	All tasks will be reviewed by the Maintenance Director. Any deficiencies within residents rooms will be presented to the QAPI committee. Date of Compliance 10/27/2023	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) 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 utilize power strips in accordance	K 920	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN	10/27/23

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K 920	Continued From page 14 with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize power strips could result in Patient Care Related Electrical Equipment (PCREE) working improperly, resulting in injury or death in the event of a malfunction. The deficiency affected four (4) of multiple resident rooms, and could potentially affect the residents of those rooms. The findings were: Observation on 10/03/23 starting at 11:36 AM revealed power strips located in patient care areas while PCREE was present. Observation of resident rooms 508, 505, 513, and 415 revealed oxygen concentrators and CPAP machines that were located near power strips or plugged directly into a power strip. PCREE shall not be plugged into power strips, and power strips shall not be located in the patient care area when PCREE is present. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920	AFFECTED BY THE DEFICIENT PRACTICE: All rooms have been inspected on October 23, 2023, to make certain that power cords are utilized in a proper manner. Power cords have been removed from rooms with improper utilization. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk of being affected by the alleged deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Staff have been educated in the proper use of a power cord. The Maintenance Director/designee will complete a power cord audit weekly for 4 weeks then monthly for 2 months. The audits will be recorded on TELS. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The Maintenance Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a	

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K 920	Continued From page 15	K 920	summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. Date of Compliance 10/27/2023	