| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535026 | A. BUILDING **01**<br>B. WING _____ | **04/04/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG HORN REHABILITATION AND CARE CENTER** | **1851 BIG HORN AVE**<br>**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 |
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| E 000 | Initial Comments<br><br>An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/04/2024. 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<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 04/04/2024.<br><br>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.<br><br>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 75 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. | K 000 | | |
| K 222 SS=F | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>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:<br>CLINICAL NEEDS OR SECURITY THREAT | K 222 | | 5/25/24 |

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

Electronically Signed | 04/22/2024

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 222 | Continued From page 1<br>LOCKING<br>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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies | K 222 | | |

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| K 222 | Continued From page 2<br>installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain means of egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain means of egress doors could result in a slow or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected two (2) exterior gates used by staff, patients, and visitors.<br><br>The findings were:<br><br>Observation on 04/04/2024 at 11:28 AM revealed two (2) exterior gates that are part of the fenced courtyard. Observation revealed that those two gates were being locked with combination padlocks. The fenced courtyard is part of the required means of egress from the facility due to two (2) exit doors, marked with exit signs, that lead into the courtyard. The courtyard has no other means of egress than the two locked gates. Doors located in the required means of egress shall not be equipped with a latch or lock that requires the use of a tool, key, or special knowledge from the egress side unless permitted | K 222 | K222<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br>All locks on the south courtyard exterior gates were removed on 4/17/24. The south exits will remain clear in case of an emergency.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br>All residents are at risk of being affected by this alleged deficient practice.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br><br>NHA educated Maintenance Director and | |

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| K 222 | Continued From page 3<br>by the LSC.<br><br>Interview with the maintenance manager at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement.<br><br>Interview with the administrator at the time of the exit acknowledge the deficiency.<br><br>Ref: 2012 NFPA 101 19.2.2.2.4 | K 222 | maintenance assistant on 4/19/24 that all emergency exit routes will remain clear to prevent a slow or inability to egress.<br>The Maintenance Director/ designee will perform monthly audits on all exit routes. All emergency exit routes will remain clear to prevent a slow or inability to egress. All audits will be recorded on TELS.<br><br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br><br>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. | |
| K 321 SS=E | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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 | K 321 | | 5/25/24 |

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| K 321 | Continued From page 4<br>and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms<br>(exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces<br>(over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>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 in the event of a fire. The deficiency affected one (1) hazardous room, and has the potential to affect all residents, staff, and visitors.<br><br>The findings were:<br><br>Observation on 04/04/2024 at 11:26 AM revealed that the facility failed to protect all hazardous areas. Observation of a storage room located in the chapel revealed a large amount of combustible storage. The room was greater than 50 square feet in area and the door was not | K 321 | K321<br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br><br>A commercial grade self-closing device was installed on the chapel storage room door on 4/17/24. This mechanism allows for the door to self-close completely. All items will be safely secured within a room, eliminating the spread of fire.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: | |

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| K 321 | Continued From page 5<br>equipped with an automatic or self-closing device. Storage rooms greater than 50 square feet and used to store combustible supplies shall be protected with a door that is self-closing or automatic-closing.<br><br>Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement.<br><br>Interview with the administrator at the time of exit acknowledge the deficiency.<br><br>Ref: 2012 NFPA 101 19.3.2.1.3; 19.3.2.1.5(7) | K 321 | All residents are at risk of being affected by this alleged deficiency.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>The Maintenance Director and Maintenance Assistant were educated on 4/19/24 that all storage room doors require a self-closing device that allows the door to self-close completely.<br><br>The Maintenance Director/designee will audit all storage rooms on the location every month. The audits will be recorded on TELS.<br><br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br><br>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. | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101 | K 345 | | 5/25/24 |

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| K 345 | Continued From page 6<br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings were:<br><br>Document review on 04/04/2024 starting at 1:10 PM revealed that the facility failed to conduct all required testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the facility had conducted the smoke detector sensitivity testing in the last two (2) years.<br><br>Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement.<br><br>Interview with the administrator at the time of the | K 345 | K345<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br><br>The fire alarm sensitivity test was scheduled for 5/25/24 with a licensed fire alarm inspector. The devices will be tested for sensitivity every two years.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br><br>All residents are at risk of being affected by this deficiency.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br><br>The Maintenance Director and Maintenance Assistant were educated on | |

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| K 345 | Continued From page 7<br>exit acknowledge the deficiency.<br><br>Ref: 2010 NFPA 72 Table 14.4.5(15)(i) | K 345 | 4/19/24 that the fire alarm sensitivity test is required to be completed every two years by a licensed firer alarm inspector.<br><br>A new contract was signed on 04/04/2024 for an ongoing sensitivity inspection. A task was placed onto TELS on a two your rotation. All documentation will be filed/recorded on TELS.<br><br>V. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br><br>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 | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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. | K 353 | | 5/25/24 |

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| K 353 | Continued From page 8<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>The findings were:<br><br>Document review on 04/04/2024 starting at 1:10 PM revealed that the facility failed to test or replace sprinkler heads that are over 50 years old. Document review revealed that the fire sprinkler contractor had noted that the sprinkler heads have been in service for over 50 years and need to be replaced, or a representative sample needs to be submitted to a testing laboratory for field service testing. No documentation was available at the time of the survey to demonstrate that either of those options had been conducted.<br><br>Interview with the maintenance director at the | K 353 | K353<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br><br>A 50-year fire suppression inspection has been scheduled with a certified contractor on 4/15/24. The fire sprinklers will be tested and replaced if needed.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br><br>All residents are at risk of being affected by this alleged deficient practice.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br><br>Maintenance Director and Maintenance | |

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| K 353 | Continued From page 9<br>time of observation acknowledge the deficiency, and indicated that they were aware of the requirement.<br><br>Interview with the administrator at the time of the exit acknowledge the deficiency.<br><br>Ref: 2011 NFPA 25 5.3.1.1, 5.3.1.1.1<br><br>Document review on 04/04/2024 starting at 1:10 PM revealed that the facility failed to test or replace dry sprinkler heads that are over 10 years old. Document review revealed that the fire sprinkler contractor had noted that the dry sprinkler heads have been in service for over 10 years and need to be replaced, or a representative sample needs to be submitted to a testing laboratory for field service testing. No documentation was available at the time of the survey to demonstrate that either of those options had been conducted.<br><br>Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement.<br><br>Interview with the administrator at the time of the exit acknowledge the deficiency.<br><br>Ref: 2011 NFPA 25 5.3.1.1, 5.3.1.1.1.6 | K 353 | Assistant were educated on 4/19/24 about the fire sprinkler need to be tested with a 50-year fire suppression inspection by a certified contractor.<br><br>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.<br><br>V. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br><br>TELS task has been scheduled for sprinkler system. On a quarterly basis. Monitoring will be completed via TELS alerts.<br><br>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. | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing | K 918 | | 5/25/24 |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BIG HORN REHABILITATION AND CARE CENTER** | **1851 BIG HORN AVE**<br>**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 |
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| K 918 | Continued From page 10<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities. Failure to properly test and maintain the EES could result in | K 918 | K918<br><br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535026 | A. BUILDING **01**<br>B. WING _____ | **04/04/2024** |

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| K 918 | Continued From page 11<br>a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors.<br><br>The findings were:<br><br>Document review on 04/04/2024 starting at 1:10 PM revealed that the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation.<br><br>Interview with maintenance personnel at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement.<br><br>Interview with the administrator at the time of the exit acknowledge the deficiency.<br><br>Ref: 2010 NFPA 99 6.4.4.1.2.1 | K 918 | PRACTICE:<br><br>Inspections of the main and feeder circuit breakers have been scheduled with a third-party electrician on 4/23/24. The inspector will test for any deficiencies in the electrical system. This will ensure that emergency equipment will continue to have power.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br><br>All residents are at risk of being affected by the alleged deficient practice.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br><br>Maintenance Director and Maintenance Assistant were educated on 4/19/24 about the need for the main and feeder circuit breakers to be scheduled annually with a third-party electrician to test for deficiencies.<br><br>The power system will be inspected by an electrician on a yearly cycle. A task has been created on TELS for an inspection on an annual rotation. Visual inspections will be completed by the Maintenance Director/ designee monthly. All documentation will be recorded on TELS. | |

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| K 918 | Continued From page 12 | K 918 | IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br><br>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. | |