STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING **01** B. WING _____	**03/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	**711 ONYX STREET** **KEMMERER, WY 83101**

(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 03/26/2024 and 03/27/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	E 031		4/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2024

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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E 031	Continued From page 1 *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide contact information for local, tribal, regional, State, and Federal emergency preparedness officials. The findings were: Review of the emergency preparedness plan on 03/27/2024 starting at 8:40 AM revealed that the plan did not include contact information for Federal emergency preparedness staff. Interview with the DON and the director of quality and compliance at the time of observation acknowledged the lack of contact information. Interview with the DON, director of quality and compliance, and maintenance personnel at the time of exit acknowledged the deficiency.	E 031	Federal contacts were added to the Emergency Preparedness plan and approved through the approval process.	
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an	E 034		4/18/24

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E 034	Continued From page 2 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to have a plan to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident commander, or designee. The findings were: Review of the emergency preparedness plan on 03/27/2024 starting at 8:40 AM revealed that the plan did not include a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the	E 034	This communication was added to the vulnerable population section of the Emergency Preparedness Plan. This plan has been approved through the approval process.	

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E 034	Continued From page 3 authority having jurisdiction, the incident commander, or designee. Interview with the DON and the director of quality and compliance at the time of observation acknowledged the lack of information. Interview with the DON, director of quality and compliance, and maintenance personnel at the time of exit acknowledged the deficiency.	E 034		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/26/2024 and 03/27/2024. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single-story building with a basement of Type II (111) construction built in 1998. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and an addressable fire alarm. The facility had a capacity of 24 certified Medicaid beds with a census of 17 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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	K 353		4/16/24

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K 353	Continued From page 4 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain water-based fire protection systems in accordance with NFPA 101, Life Safety Code, NFPA 13, The Standard for the Installation of Sprinkler Systems, and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency affected multiple sprinkler heads throughout the facility. The findings were: Observation on 03/26/2024 at 3:26 PM in the kitchen revealed several sprinkler heads that had a large amount of dust loaded on the device. Any sprinkler that shows signs of loading shall be cleaned with compressed air or vacuumed. Interview with maintenance personnel at the time of observation acknowledged the deficiency, and	K 353	SLHD's plant operations department will inspect and clean all sprinkler heads in the kitchen area showing signs of dust and dirt accumulation. The correction was completed on 04/16/2024. SLHD's plant operations director will set up a preventive maintenance work order in the CMMS program for SLHD maintenance staff to complete every six months to inspect and clean all facility sprinkler heads. The plant operations director will also ensure that the vendor completes the annual fire system check in accordance with 2012 NFPA 101 Ch. 32 Sec. 2.3.5, Ch. 9 Sec. 7.1; 2010 NFPA 13 Ch. 26 Sec. 1; 2011 NFPA 25 Ch. 5, Sec. 2.1.1.2(5) and Annex A.	

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K 353	Continued From page 5 indicated that he was aware of the requirement. Interview with the DON, director of quality and compliance, and maintenance personnel at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 Ch. 32 Sec. 2.3.5, Ch. 9 Sec. 7.1; 2010 NFPA 13 Ch. 26 Sec. 1; 2011 NFPA 13 Ch. 5, Sec. 2.1.1.2(5) and Annex A.5.2.1.1.2(5)	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an unobstructed area around portable fire extinguishers in accordance with the NFPA 101, Life Safety Code, and the NFPA 10, Standard for Portable Fire Extinguishers. Failure to maintain an unobstructed area around portable fire extinguishers could result in injury or death in the event of a fire. The findings were: Observation on 03/27/2024 at 3:21 PM in the kitchen revealed a fire extinguisher that was partially blocked and obscured by a cart. Fire extinguishers shall not be obstructed or obscured from view. Interview with the activities director at time of	K 355	SLHD's dietary supervisor, as a key player in maintaining safety standards, will ensure the food cart is stored in a safe area in compliance with 2012 NFPA 101Ch. 33, Sec. 3.3.5.7, Ch. 9, Sec. 7.4.1; and 2010 NFPA 10 Ch. 1 sec. 6.6. This area should be away from the fire extinguisher and positioned so as not to block any means of egress. The correction will be completed by 05/26/2024. SLHD's dietary supervisor will conduct daily checks to ensure the food cart is parked in the appropriate location so as not to block access to the fire extinguisher or egress routes.	5/26/24

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K 355	Continued From page 6 observation acknowledged the deficiency, and indicated she was not aware of the requirement. Interview with the DON, director of quality and compliance, and maintenance personnel at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 Ch. 33, Sec. 3.3.5.7, Ch. 9, Sec. 7.4.1; 2010 NFPA 10 Ch. 1, Sec. 6.6	K 355		
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 the HVAC system in accordance with the NFPA 101, Life Safety Code, and NFPA 90A, Standard for the Installation of Air-conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC system could result in a failure of the system which could result in injury or death in the event of a fire. The deficiency affected the HVAC system and has the potential to affect all residents, staff, and visitors. The findings were:	K 521	SLHD's Plant operations department will create a fire damper inspection template and inspect and test every fire damper in the facility at least once every four years in accordance with 2012 NFPA 101 19.5.2, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1. The corrections will be completed by 05/26/2024. SLHD's plant operations director will create a preventive maintenance work order in the facility CMMS program to double-check that the dampers are inspected every four years.	5/26/24

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K 521	Continued From page 7 Document review on 03/27/2024 starting at 8:40 AM revealed there was no documentation available to demonstrate that the facility's fire dampers had been tested as required. Fire damper shall be inspected and tested once every four (4) years. Interview with maintenance personnel at the time of observation acknowledged the deficiency, and indicated that he was aware of the requirement. Interview with the DON, director of quality and compliance, and maintenance personnel at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 19.5.2, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521		