STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

(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 06/24/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an	E 004		7/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2024

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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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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E 004	Continued From page 1 all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain an Emergency Preparedness Plan in accordance with 42 CFR 483.73. Failure to maintain an Emergency Preparedness Plan as required could result in delayed facility response during an emergency leading to injury or death. The findings were: Document review on 6/24/2024 at 1:30 PM revealed the facility was not able to provide documentation demonstrating that the facility's Emergency Preparedness Plan had been reviewed and updated within the past 12 months.	E 004	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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E 004	Continued From page 2	E 004	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s emergency preparedness plan (EPP) was reviewed and updated on 7/1/2024. By the Nursing Home Administrator (NHA) II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The new updated emergency preparedness manual was audited and reviewed for compliance by the Director of Operations on 7/2/24 no other issues with plan were noted III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/1/2024 the Maintenance Director was provided an education in-service by the NHA regarding having EPP binder updated at least yearly and/or as needed. The Maintenance Director/designee will audit EPP during monthly Safety Committee meetings to ensure that any facility-related updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately.	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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E 004	Continued From page 3	E 004	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.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (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]. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain an Emergency Preparedness Communication Plan in accordance with 42 CFR 483.73. Failure to	E 029	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR	7/22/24

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E 029	Continued From page 4 maintain an Emergency Preparedness Plan as required could result in delayed facility response during an emergency leading to injury or death. The findings were: Document review on 6/242024 at 1:30 PM revealed the facility was not able to provide documentation demonstrating that the facility's Emergency Preparedness Communication Plan had been reviewed and updated within the past 24 months.	E 029	AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s communication plan was reviewed and updated on 7/16/2024. By the Nursing Home Administrator (NHA) II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: the Director of Operations audited the facilities communication plan for compliance on 7/16/2024 no other issues were identified III. MEASURES OR SYSTEMIC	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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E 029	Continued From page 5	E 029	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/16/2024 the Maintenance Director was provided and education in-service by the NHA regarding the facilities communication plan quarterly/updated at least yearly and/or as needed. The Maintenance Director/designee will audit during monthly Safety Committee meetings to ensure that any facility-related updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately. The validation of this communication plan is scheduled for 29 July 2024 with Sarah Lentz of Laramie County. 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 are required.	
K 000	INITIAL COMMENTS	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 6 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 06/24/2024. 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 of Type V (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with an antifreeze branch, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 64 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm	K 345	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR	7/22/24

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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K 345	Continued From page 7 Code. Failure to maintain fire detection systems as required could result in a failure of equipment during an emergency, leading to injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 06/24/2024 starting at 1:30 PM revealed the facility was not able to provide documentation demonstrating that the fire alarm system monthly activation was accomplished. Specifically, documentation provided only demonstrated the fire alarm system was activated for testing two (2) of the last twelve (12) months. Interview with maintenance personnel at the time of observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sec. 19. 3.4.1, 9.6.1.3; 2010 NFPA 72, Table 14.4.5 (24)	K 345	AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s fire and smoke alarm system tested, reviewed and updated on 7/14/2024, by Maintenance Director II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The facility□s fire and smoke alarm system was inspected for compliance by Nursing Home Administrator (NHA) on 7/15/24	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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K 345	Continued From page 8	K 345	III.MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/14/2024 the Maintenance Director was provided and education in-service by the NHA regarding having fire and smoke alarm testing update at least monthly/quarterly/ yearly and/or as needed. The Maintenance Director/designee will audit fire, smoke alarm system during monthly Safety Committee meetings to ensure that any facility-related updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately. 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.	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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K 353	Continued From page 9	K 353		
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 by: Based on observation and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain fire sprinkler systems as required may result in a malfunction or failure of the system during a fire, resulting in injury or death. The deficiency affected the anti-freeze section of the system. Document review on 6/24/2024 starting at 1:30 PM revealed that no documentation was available to demonstrate that the anti-freeze system had been tested within the last 12 months. The	K 353	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH	7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET** **CHEYENNE, WY 82001**

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K 353	Continued From page 10 anti-freeze freezing point must be tested annually. Interview with maintenance personnel at the time of observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sec. 19.3.5.1, 9.7.5; 2011 NFPA 25, Table 5.1	K 353	FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s sprinkler system was reviewed and updated on 7/16/2024. By Maintenance Director II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On 7/17/24 the facility□s sprinkler system was tested and reviewed by Nursing Home Administrator (NHA) no other issues were identified during this time. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/16/2024 the Maintenance Director was provided and education in-service by the NHA regarding the facilities sprinkler system quarterly/updated at least yearly and/or as needed. The Maintenance Director/designee will audit during monthly Safety Committee meetings to ensure that any facility-related	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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K 353	Continued From page 11	K 353	updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately. 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 are required.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374		7/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 374	Continued From page 12 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors in smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide doors in smoke barriers as required could result in the propagation of smoke, which may hinder egress, and result in injury or death. The deficiency could impact all residents, staff, and visitors within the area of the observation. The findings were: Observation on 06/24/2024 at 11:41 AM at the smoke compartment doors leading into the Yellowstone hall revealed that, when released from the fully-open position, and when the door equipped with an astragal was allowed to close first, the door-closer coordinator would not allow the doors to fully close, creating a space for the passage of smoke. Interview with maintenance personnel at the time of observation confirmed the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sections 19.3.7.8, 8.5.4	K 374	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s smoke barrier/doors test was reviewed and updated by 7/16/2024, by Maintenance Director II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE	

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	535025	A. BUILDING **01** B. WING _____	**06/24/2024**

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K 374	Continued From page 13	K 374	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The facility□s smoke barrier doors were inspected and audited for compliance by Nursing Home Administrator (NHA) on 7/17/24 no other area of concern were found. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/16/2024 the Maintenance Director was provided and education in-service by the NHA regarding having a smoke barrier/door test quarterly/updated at least yearly and/or as needed. The Maintenance Director/designee will audit during monthly Safety Committee meetings to ensure that any facility-related updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately. 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	

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K 374	Continued From page 14	K 374	the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	
K 900 SS=E	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain main and feeder circuit breakers in accordance with 2012 NFPA 99, Heath Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency affected the facilities main and backup electric system. The findings were: Document review on 06/24/2024 starting at 1:30 PM revealed the facility was not able to provide documentation demonstrating that the main and feeder circuit breakers had been tested. Main and feeder circuit breakers shall be inspected annually, and a program for periodically exercising the components shall be established according to manufacturer's recommendations. Interview with maintenance personnel at the time of observation confirmed the deficiency, and	K 900	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND	7/22/24

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K 900	Continued From page 15 indicated that they were not aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 Ch.10 Sec. 4.4.1.2	K 900	SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility□s main and feeder circuit breaker test was reviewed and updated on 7/15/2024 By Maintenance Director II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: the facility□s main and feeder circuit breaker was inspected for compliance by Executive Director on 7/16/24 no other issues were noted III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 7/15/2024 the Maintenance Director was provided an education in-service by the NHA regarding having a circuit breaker test quarterly/updated at least yearly and/or as needed. The Maintenance Director/designee will audit during monthly Safety Committee meetings to ensure that any facility-related updates are made timely. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately.	

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K 900	Continued From page 16	K 900	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.	