STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR** **CASPER, WY 82601**

(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 05/11/2024 and 05/12/2024. 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	E 004		7/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2024

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 004	Continued From page 1 requirements of this section, utilizing an 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 6/12/2024 at 9:00 AM 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 24 months. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency.	E 004	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 by 7/8/2024. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:	

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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(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 004	Continued From page 2	E 004	By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee 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. 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 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),	E 031		7/8/24

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E 031	Continued From page 3 §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. *[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 maintain emergency official's contact information within their emergency preparedness plan in accordance with 42 CFR 483.73. Failure to maintain emergency official's	E 031	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility's Emergency Preparedness	

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E 031	Continued From page 4 contact information as required could result in delayed facility response during an emergency leading to injury or death. The findings were: Document review on 6/12/2024 starting at 9:00 AM revealed that contact information for the state licensing and certification agency, and office of the state long-term care ombudsman,was missing from the emergency preparedness plan. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency.	E 031	Plan emergency officials contact information was updated by 7/8/2024 to include contact information for the state licensing and certification agency, and office of the state long-term care ombudsman. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee regarding having emergency contact information updated in the EPP binder. 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. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:	

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E 031	Continued From page 5	E 031	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 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA	E 041		7/8/24

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E 041	Continued From page 6 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of	E 041		

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E 041	Continued From page 7 _federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to record monthly generator battery tests in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Failure to perform monthly generator battery tests as required could result in power loss during an emergency. The deficiency	E 041	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility's recorded monthly generator battery test in accordance with NFPA 110, Standard for Emergency and Standby	

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E 041	Continued From page 8 affected facility-wide reliability of the emergency power system. The findings were: Document review and interview with the maintenance manager on 06/12/2024 starting at 9:00 AM revealed that no record of monthly generator battery specific gravity or conductance tests was available. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.5.1.1, 9.1, 9.1.3.1; 2010 NFPA 110, Sections 8.2.4, 8.3.7.1	E 041	Power Systems. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee NHA/designee was provided and education in-service by the NHA/designee regarding generator testing monthly. Maintenance Director/designee will perform monthly generator battery test in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. The audit will be conducted monthly for 3 months until substantial compliance is achieved. Any identified concerns will be addressed immediately. 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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E 041	Continued From page 9	E 041	the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 05/11/2024 and 05/12/2024. 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 (111) construction with plan approval in 1967 and 1973. The building was equipped with a supervised wet sprinkler system with an anti-freeze branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 74 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		7/8/24

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K 211	Continued From page 10 by: Based on observation and staff interview, the facility failed to maintain a clear egress corridor in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain a clear means of egress as required could delay egress resulting in injury or death in the event of an emergency. The deficiency affected one (1) of multiple means of egress in the facility. The findings were: Observation on 06/11/2024 at 4:06 PM in the kitchen revealed food delivery carts blocking the emergency exit access and door. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sections 7.1.10	K 211	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen area where food delivery carts were blocking the emergency exit access and door was cleared during the time of survey on 6/11/2024. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee on maintaining means of egress continuously free of all obstructions or impediments to full instant use in the case of fire or other emergency. By 7/8/2024 the Maintenance Director/designee completed an audit of all emergency exit access doors to ensure that means of egress are continuously free of all obstructions. Maintenance Director/designee will be responsible for completing weekly audits x 4 weeks, then monthly audits for 2 additional months to ensure facility's means of egress continuously free of all	

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K 211	Continued From page 11	K 211	obstructions or impediments. Any identified concerns will be addressed immediately. 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.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency exit signage in accordance with NFPA 101, Life Safety Code. Failure to maintain exit signage as required may result in delayed egress during an emergency	K 293	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen exit sign has been fixed and	7/8/24

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR** **CASPER, WY 82601**

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K 293	Continued From page 12 leading to injury or death. The deficiency affected one emergency exit sign in the facility and affected the kitchen staff. The findings were: Observation on 06/11/2024 in the kitchen revealed an exit sign that was not illuminated. Exit signs shall be continuously illuminated. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sec 19.2.10.1, 7.10.5	K 293	is properly illuminated. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee on ensuring all facility exit signs are continuously illuminated. By 7/8/2024 the Maintenance Director/designee completed an audit of all exit signs in the community to ensure they are continuously illuminated. Maintenance Director/designee will perform weekly audits x 4 weeks, then monthly audits for 2 additional months to ensure all facility exit signs are continuously illuminated. Any identified concerns will be addressed immediately. 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	

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 293	Continued From page 13	K 293	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=D	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 Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Document review on 6/12/2024 starting at 9:00 AM revealed that the facility was able to produce documentation demonstrating the Fire Alarm System had been tested within the last 12 months. However, the documentation did not	K 345	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Fire Alarm System has been tested to provide a location and pass/fail test for the alarm notification devices as required in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm Code. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	7/8/24

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 345	Continued From page 14 provide a location and pass/fail test for the alarm notification devices as required. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: NFPA 101, Sec. 19. 3.4.1, 9.6.1.3; NFPA 72, Table 14.4.5	K 345	POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee to ensure that fire alarm system testing include location and pass/fail test for the alarm notification devices per the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm Code. Maintenance Director/designee will perform monthly audits x 3 months to ensure compliance. Any identified concerns will be addressed immediately. 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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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 371 SS=D	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in accordance with NFPA101, Life Safety Code. Failure to maintain smoke barriers as required could lead to the propagation of smoke during an emergency leading to injury or death. The deficiency affected one smoke compartment door in the facility. The findings were: Observation on 06/11/2024 at 3:48 PM at the smoke compartment doors in hall 1 revealed cross-corridor doors that were self-closing or automatic-closing and held open by magnetic hold-open devices connected to the fire alarm system. When dropped with no initial motion, the doors failed to close completely. This failure was due to the lack of a door closure coordinating device. The lack of a door closure coordinating device allowed the door leaf equipped with an astragal to close first, not allowing a smoke proof seal. Interview with the maintenance manager at the	K 371	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility contacted an outside contractor to have Hall 1 cross-corridor, smoke compartment doors to be repaired by installing a door closure coordinating device and to close completely to maintain smoke barriers in accordance with NFPA101, Life Safety Code. 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, staff and visitors are at risk of being affected by this alleged deficiency.	7/8/24

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K 371	Continued From page 16 time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sec. 19.3.7.8, 8.5.4	K 371	MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee to ensure that all smoke compartment doors close completely. By 7/8/2024 the Maintenance Director/designee checked all other smoke compartment doors to ensure they close completely. The Maintenance Director/designee will perform weekly audits x 4 weeks, then monthly audits for 2 additional months to ensure compliance. Any identified concerns will be addressed immediately. 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.	
K 900 SS=E	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other	K 900		7/8/24

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 900	Continued From page 17 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 06/12/2024 starting at 9:00 AM revealed the facility was not able to provide documentation demonstrating that the main and feeder circuit breakers had been tested. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 Ch.10 Sec. 4.4.1.2	K 900	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility contacted an outside contractor to have their main and feeder circuit breakers tested. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee to ensure the facility's main and feeder circuit breakers have been tested in accordance with 2012 NFPA 99, Heath Care Facilities Code. The Maintenance Director/designee will perform monthly	

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 900	Continued From page 18	K 900	audits x 3 months to ensure compliance. Any identified concerns will be addressed immediately. 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.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide properly installed electrical	K 912	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN	7/8/24

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K 912	Continued From page 19 equipment in accordance with NFPA 101, Life Safety Code, and NFPA 70, National Electric Code. Failure to properly install electrical equipment as required could result in electric shock, leading to injury or death. The deficiency affected several electrical devices in the facility. The findings were: 1. Observation on 06/11/2024 at 3:27 PM in the social services office revealed an electrical receptacle that was hanging from its enclosure on the wall, exposing electrical conductors. Further observation revealed that the receptacle was improperly installed. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sec. 19.5.1.1, 9.1.2; 2011 NFPA 70 Sec. 406.5 2. Observation on 06/11/2024 at 3:35 PM in the main boiler room revealed several junction boxes without coverings exposing electrical conductors. Openings through which conductors enter shall be adequately closed. Interview with the maintenance manager at the time of observation confirmed the deficiency and indicated that he was aware of the requirement. Interview with the chief operating officer, administrator, and maintenance manager at the time of exit confirmed the deficiency.	K 912	AFFECTED BY THE DEFICIENT PRACTICE: The social services office electrical receptacle that was hanging from its enclosure on the wall, has been repaired and properly installed in accordance with NFPA 101, Life Safety Code, and NFPA 70, National Electric Code. 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, staff and visitors are at risk of being affected by this alleged deficiency. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 7/8/2024 the Maintenance Director/designee was provided and education in-service by the NHA/designee to ensure facility's electrical receptacles are in good condition and properly installed. By 7/8/2024 the maintenance director/designee audited facility's electrical receptacles with concerns corrected as needed. The Maintenance Director/designee will perform weekly audits throughout the facility x 4 weeks, then monthly for 2 additional months to ensure compliance in accordance with NFPA 101, Life Safety Code, and NFPA 70, National Electric	

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	535024	A. BUILDING **01** B. WING _____	**06/12/2024**

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K 912	Continued From page 20 Ref: Ref: 2012 NFPA 101 Sec. 19.5.1.1, 9.1.2; 2011 NFPA 70 Sec. 314.17 (A)	K 912	Code. 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.	