STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **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 08/05/2024 and 08/06/2024. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/05/2024 and 08/06/2024. 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 three story building with a basement of Type II (222), and type II (111) construction with plan approval in 1966 and 1972. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 83 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90	K 000		
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the	K 100		8/31/24

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

Electronically Signed | 08/30/2024

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 100	Continued From page 1 applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain ceiling systems in accordance with NFPA 101, Life Safety Code. Failure to maintain ceiling systems as required could contribute to smoke and fire propagation throughout the facility, delay the response time of the fire suppression system, and delay egress during a fire. The deficiency was widespread throughout the facility and could impact all residents, staff, and visitors. The findings were: Observation on 08/05/2024 at 12:13 PM in the kitchen revealed a missing ceiling tile. Further observation found the deficiency persisted throughout the facility. Additional observation revealed that the ceiling grid in some areas was rusted and misaligned, causing gaps in the ceiling tile grid in several areas of the facility. 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 facility administrator at the time of exit confirmed the deficiency. Ref. 2012 NFPA 101 Sec. 19.1.1.1.3 and 4.6.12.1	K 100	Preparation and execution of the 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 the state and federal 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 the State Operations Manual. K 100 General requirements CORRECTIVE ACTION The ceiling tile was replaced in the kitchen on 8/5/24 by the Maintenance Team. The ceiling tiles were sanded, painted and re-aligned on 8/15/24. IDENTIFICATION OF OTHERS The Maintenance Team conducted rounds of the Center on 8/5/24 any identified missing tiles were replaced. The maintenance team conducted rounds of the Center on 8/5/24 to identify any	

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K 100	Continued From page 2	K 100	other rusted or mis-aligned tiles. Any identified were sanded, painted and re-aligned. STEMIC CHANGE The maintenance team conducts monthly rounds of the ceiling tiles to ensure none are missing, rusted or out of alignment. Any identified are corrected at that time. In-service education was provided to the maintenance team regarding missing rusted or mis-aligned ceiling tiles and correction of the issues prior to 8/31/24. MONITORING The Maintenance Director brings the results of the ceiling tile audit to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors 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: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		8/31/24

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K 222	Continued From page 3 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. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS 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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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K 222	Continued From page 4 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected one (1) of multiple exit doors in the facility. The findings were: Observation on 08/05/2024 at 12:29 PM at the east lobby exit revealed an emergency exit equipped with a delayed-egress lock. Further observation revealed that the delayed-egress locking system would not operate as designed. 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 facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, 19.2.2.2.1 and 7.2.1.6.1.1	K 222	K 222 CORRECTIVE ACTION The east lobby exit door was repaired on 8/27/24 by an outside contractor. IDENTIFICATION OF OTHERS The maintenance team audited all other exit doors to ensure that all were operating as designed 8/5/24. No other concerns were identified. STEMIC CHANGE The maintenance team audits the exit doors monthly to ensure that all doors operate as designed. In-service education was provided to the maintenance team prior to 8/31/24 related to ensuring that all exit doors operate as designed. MONITORING	

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K 222	Continued From page 5	K 222	The Maintenance Director brings the results of the exit door audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
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 NFPA 72, National Fire Alarm and Signaling Code. Failure to maintain fire alarm systems as required could result in a system failure leading to delayed notification during a fire. The findings were: Document review on 08/06/204 starting at 8:05 AM revealed the facility was not able to produce documentation demonstrating semi-annual sealed lead acid battery inspection or load voltage testing for the fire alarm system backup batteries.	K 345	K 345 Fire Alarm System CORRECTIVE ACTION The Center contacted the vendor who conducts the sealed lead acid battery inspection or load voltage testing for the fire alarm system backup batteries and the vendor provided the documentation for the test. IDENTIFICATION OF OTHERS The Center only has 1 battery backup	8/31/24

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K 345	Continued From page 6 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 facility administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d) and 14.4.5(6)(3)	K 345	system and all batteries are tested at the same time. STEMIC CHANGE The Maintenance Team verifies that the sealed lead acid battery inspection or load voltage testing for the fire alarm system backup batteries testing is up to date monthly. In-service education was provided to the maintenance team related to the requirements for testing of the sealed lead acid battery inspection or load voltage testing for the fire alarm system backup batteries prior to 8/31/24. MONITORING The Maintenance Director brings the results of the testing to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		8/31/24

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K 351	Continued From page 7 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire sprinkler system in accordance with NFPA 101, Life Safety Code and NFPA 13, Standard for the Installation of Sprinklers. Failure to properly install the fire sprinkler system could inhabit proper operation of the suppression system during an emergency. The deficiency affected several sprinkler heads throughout the facility. The findings were: Observation on 08/05/2024 at 11:20 AM at room 117 revealed an escutcheon that was not sealed against the ceiling tile. Further observation revealed fire sprinkler heads with missing escutcheons, exposing the annular space above. 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 facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sec. 19.3.5, 9.7; 2010	K 351	K 351 Sprinkler System CORRECTIVE ACTION The escutcheon for room 117 was sealed on 8/5/24 by the maintenance team. A walk through was conducted on 8/8/24 to identify any fire sprinkler heads with missing escutcheons and corrected them. IDENTIFICATION OF OTHERS The maintenance team conducted a walk-through of the Center on 8/8/24 to identify any additional escutcheons that were not sealed or missing. Any identified concerns were corrected. STEMIC CHANGE The Maintenance team conducts a walk through monthly to verify that all escutcheons are sealed and in place. Any	

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K 351	Continued From page 8 NFPA 13 Sec. 6.2.7.1	K 351	identified concerns are corrected at the time. In-service education was conducted on 8/29/24 with the maintenance team regarding sealing of the escutcheon and ensuring all fire sprinkler heads have escutcheons in place. MONITORING The Maintenance Director brings the results of the escutcheon audit to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
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 _____	K 353		8/31/24

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K 353	Continued From page 9 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 fire sprinkler system gauges. The findings were: Observation at the sprinkler system risers revealed system gauges that were dated 11/2018. Sprinkler system gauges shall be replaced or recalibrating every 5 years. 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 facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sec. 19.3.5.1, 9.7.5; 2011 NFPA 25 Sec. 5.3.2	K 353	K 353 Sprinkler System-Maintenance and Testing CORRECTIVE ACTION The sprinkler system gauges were replaced on 8/21/24. IDENTIFICATION OF OTHERS All gauges have the potential to be affected by this practice STEMIC CHANGE The maintenance team verifies the date on the sprinkler system gauges during their monthly audit. Any identified concerns are addressed at that time. In-service education was provided to the maintenance team on 8/31/24 regarding the 5 year requirement for replacing or recalibrating the sprinkler system gauges. MONITORING The Maintenance Director brings the results of the sprinkler system gauge audit to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no	

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K 353	Continued From page 10	K 353	concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 355 SS=E	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, document review, and staff interview, the facility failed to maintain portable fire extinguishers in accordance with NFPA 101, Life Safety Code and NFPA 10, Standard for Portable Fire Extinguishers. Failure to maintain portable fire extinguishers as required could result in the failure of equipment during a fire, leading to injury or death. The deficiency affected all of the fire extinguishers in the facility. Document review on 08/06/2024 starting at 8:30 AM revealed that the facility could not provide documentation to demonstrate that the annual inspection and six (6) year maintenance of portable fire extinguishers has been completed. The facility had documented the monthly inspection of all extinguishers. 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 facility administrator at the time of exit confirmed the deficiency.	K 355	K 355 Portable fire extinguishers CORRECTIVE ACTION The fire extinguisher report was received on 8/15/24. IDENTIFICATION OF OTHERS All fire extinguishers have the potential to be affected by this practice. STEMIC CHANGE The Maintenance team audits the fire extinguisher inspections monthly to ensure all documentation is completed and available for inspection. In-service education was provided to the maintenance team prior to 8/31/24 regarding the requirement to have the documentation to demonstrate that the annual inspection and the 6 year	8/31/24

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K 355	Continued From page 11 Ref: 2012 NFPA 101 Sec. 19.3.5.12 and 9.7.4.1; NFPA 10 Sec. 18.3.5.12, 19.3.5.12	K 355	maintenance of the portable fire extinguishers has been completed. MONITORING The Maintenance Director brings the results of fire extinguishers audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		8/31/24

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GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 363	Continued From page 12 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors in accordance with NFPA 101, Life Safety Code. Failure to maintain corridor doors as required could lead to the propagation of smoke during a fire. The deficiency affected one (1) of multiple sets of corridor doors in the facility. The findings were: Observation on 08/05/2024 at 2:38 PM at the A hall corridor revealed a set of doors that were self-closing or automatic-closing, separating smoke compartments. Further observation during testing of the closing devices revealed that the doors would not fully close to create a smoke-resistant seal. Interview with the maintenance manager at the time of observation confirmed the deficiency, and indicated that he was aware of the requirement.	K 363	K 363 Corridor Doors CORRECTIVE ACTION The set of doors on A-hall corridor now fully closes to create a smoke-resistant seal as of 8/8/24. IDENTIFICATION OF OTHERS The maintenance director audited all the corridor smoke doors to ensure that all closed appropriately on 8/8/24. No concerns were identified STEMIC CHANGE The maintenance team audits the corridor smoke doors monthly to verify that all fully close to create a soke-resistant seal.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING **01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE** **CHEYENNE, WY 82001**

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K 363	Continued From page 13 Interview with the facility administrator at the time of exit confirmed the deficiency. 2012 NFPA 101 Sec. 19.3.6.3.2(2)	K 363	In-service education was provided to the maintenance team prior to 8/31/24 regarding the requirement of all corridor smoke doors to fully close and create a smoke-resistant seal. MONITORING The Maintenance Director brings the results of the corridor smoke door audit to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914		8/31/24

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	535013	A. BUILDING **01** B. WING _____	**08/06/2024**

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K 914	Continued From page 14 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain and test electrical components at patient bed locations in accordance with NFPA 99, Standard for Health Care Facilities. Failure to maintain and test electrical components at patient bed locations as required could result in a failure of components leading to electrical shock. The deficiency affected multiple electrical receptacles at patient bed locations throughout the facility. The findings were: Document review on 08/06/2024 starting at 8:05 AM revealed the facility had conducted testing of GFCI outlets in the facility as required. However, the documentation provided did not demonstrate the testing of non-hospital grade receptacles at patient bed locations. Receptacles not listed as hospital-grade at these locations are to be tested at intervals not exceeding 12 months. Interview with the maintenance manage at the time of observation confirmed the deficiency, and indicated that he was not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 Sec. 6.3.4.1, 6.3.3.2	K 914	K 914 Electrical Systems Maintenance and Testing CORRECTIVE ACTION All non-hospital grade receptacles in resident rooms were tested and documented by 8/30/24. IDENTIFICATION OF OTHERS All residents have the potential to be affected by this practice. STEMIC CHANGE The Maintenance Team audits the documentation of the non-hospital receptacles monthly to ensure that the receptacles are tested at intervals not exceeding a 12-month period. The maintenance team was provided in-service training prior to 8/31/24 regarding the requirement to documenting the testing of the non-hospital grad receptacles in resident rooms every year. MONITORING The Maintenance Director brings the results of the audit of the documentation of the non-hospital grade receptacle to the	

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K 914	Continued From page 15	K 914	Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	
K 929 SS=D	Gas Equipment - Precautions for Handling Oxyg CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to handle oxygen containers within resident rooms in accordance with NFPA 99, Standard for Health Care Facilities. Failure to appropriately handle oxygen cylinders as required could result in injury or death. The deficiency affected one (1) of multiple oxygen cylinders in the facility. The findings were: Observation on 08/05/2024 in the therapy room revealed an oxygen cylinder placed freestanding. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Interview with the maintenance manager at the	K 929	K 929 Gas Equipment CORRECTIVE ACTION The oxygen cylinder was removed on 8/5/24 by the therapy director. IDENTIFICATION OF OTHERS The maintenance team rounded the Center on 8/5/24 and verified that there were no additional free-standing oxygen cylinders in the Center. STEMIC CHANGE	8/31/24

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K 929	Continued From page 16 time of observation confirmed the deficiency, and indicated that he was aware of the requirement. Interview with the facility administrator confirmed the deficiency. Ref: 2012 NFPA 99 Sec. 11.6.2.3(11)	K 929	The Maintenance Team rounds the center monthly to verify that there are no free-standing oxygen cylinders in the Center. Any identified concerns are corrected immediately. The Maintenance Team and therapy Team was provided in-service education prior to 8/31/24 regarding not having any free-standing oxygen cylinders in the Center MONITORING The Maintenance Director brings the results of the Oxygen Cylinder Audit to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These audits will continue weekly for 3 months. If no concerns are identified these audits will be discontinued at that time unless the QAPI Committee deems it prudent to continue.	