

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05 B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC			STREET ADDRESS, CITY, STATE, ZIP CODE 8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520		
(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 01/27/25 and 01/28/25. Based on the findings of the survey, the facility is in compliance with 42 CFR 483.73.	E 000	<u>K-291</u> <u>SS=F</u> <u>Emergency Lighting</u> <u>CFR(s): NFPA 101</u>		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25. Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) 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(III) construction built in 1990. The building was equipped with a supervised, automatic wet sprinkler system with a zoned fire alarm system. The overall campus had a capacity of 20 certified beds with a census of 12 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000	<u>This STANDARD is not met as evidenced by:</u> Based on observation and staff interview, the facility failed to provide emergency lighting testing in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility. Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, but no documentation was provided that confirmed a 90-minute annual test.		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting testing	K 291	<u>Corrective Action(s):</u> The Facility Operations Manager or designee will conduct monthly thirty (30) second and annual ninety (90) minute testing on the emergency lighting appliances. All testing will be documented for record-keeping purposes.	03/14/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Christine Symanski

TITLE

SNF Administrator

(X6) DATE

2/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 291	Continued From page 1 in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, and no documentation was provided that confirmed a 90 minute annual test. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 291	<u>K-291 (Con't)</u> <u>SS=F</u> <u>Emergency Lighting</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve event detection, optimize cause analysis, and build best practices. The committee will also review and address any compliance issues.		
K 345 SS=F	REF: 2012 NFPA 101, Section: 13.2.9.1, 7.9 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 test and maintain the fire	K 345			

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K 345	Continued From page 2 alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was: Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not 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)	K 345	<u>K-345</u> <u>SS=F</u> <u>Fire Alarm System – Testing and Maintenance</u> <u>CFR(s): NFPA 101</u> This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. Document review on 1/28/25 starting at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months.		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to	K 355	<u>Corrective Action(s):</u> The Facility Operations Manager or designee will conduct a fire alarm battery inspection every six (6) months. All inspections and testing will be documented for record-keeping purposes.	03/14/2025	

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K 345	Continued From page 2 alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was: Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not 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)	K 345	<u>K-345 (Con't)</u> <u>SS=F</u> <u>Fire Alarm System – Testing and Maintenance</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 355	Portable Fire Extinguishers SS=D 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 staff interview, the facility failed to	K 355			

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K 355	Continued From page 3 provide a placard at the K-type extinguisher in accordance with the 2012 NFPA 101, Life Safety Code, the 2010 NFPA 10, Standard for Portable Fire Extinguishers. The failure to have a placard as required could result in injury or death due in an emergency. The deficiency affected one (1) of one (1) kitchen K-type extinguishers for the facility. The findings were: Observation on 1/27/25 at 3:41 PM in the kitchen at the extinguisher to the right of the Ansul pull location revealed there was no placard conspicuously placed near the K-type extinguisher, stating the fire protection system shall be actuated prior to using the fire extinguisher. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 10 5.5.5.3	K 355	<u>K-355</u> <u>SS=D</u> <u>Portable Fire Extinguishers</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced by:</u> Based on staff interview, the facility failed to provide a placard at the K-type extinguisher in accordance with the 2012 NFPA 101, Life Safety Code, the 2010 NFPA 10, Standard for Portable Fire Extinguishers. The failure to have a placard as required could result in injury or death due in an emergency. The deficiency affected one (1) of one (1) kitchen K-type extinguishers for the facility. Observation on 1/27/25 at 3:41 PM in the kitchen at the extinguisher to the right of the Ansul pull location revealed there was no placard conspicuously placed near the K-type extinguisher, stating the fire protection system shall be actuated prior to using the fire extinguisher. <u>Corrective Action(s):</u> The Facility Operations Manager or designee will ensure proper fire extinguisher placard placement for all portable fire extinguishers. <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.	03/14/2025	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918			

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K 355	Continued From page 3 provide a placard at the K-type extinguisher in accordance with the 2012 NFPA 101, Life Safety Code, the 2010 NFPA 10, Standard for Portable Fire Extinguishers. The failure to have a placard as required could result in injury or death due in an emergency. The deficiency affected one (1) of one (1) kitchen K-type extinguishers for the facility. The findings were: Observation on 1/27/25 at 3:41 PM in the kitchen at the extinguisher to the right of the Ansul pull location revealed there was no placard conspicuously placed near the K-type extinguisher, stating the fire protection system shall be actuated prior to using the fire extinguisher. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 10 5.5.5.3	K 355	<u>K-355 (Con't)</u> <u>SS=D</u> <u>Portable Fire Extinguishers</u> <u>CFR(s): NFPA 101</u> Responsible Person(s): The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 918	Electrical Systems - Essential Electric Syste SS=F CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918			

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K 918	Continued From page 4 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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 had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising	K 918	<u>K-918</u> <u>SS=F</u> <u>Electrical Systems – Essential Electric System</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced by:</u> 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 had the potential to impact all residents, staff, and visitors within the facility. Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. 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. <u>Corrective Action(s):</u> The Facility Operations Manager or designee will create an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. Main	03/14/2025	

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K 918	Continued From page 5 electrical components in accordance with manufacturer's recommendations. 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 the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 918	<u>K-918 (Con't)</u> <u>SS=F</u> <u>Electrical Systems – Essential Electric</u> <u>System</u> <u>CFR(s): NFPA 101</u> and feeder circuit breakers will be inspected annually, and a program for periodically exercising the components shall be established according to manufacturer's recommendations All inspections and exercising and program development will be documented for record-keeping purposes.		
K 923 SS=D	Ref: 2012 NFPA 99, Section 10.4.4.1.2 Gas Equipment - Cylinder and Container Stora CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923	<u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		

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K 923	Continued From page 6 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store helium in accordance with the 2012 NFPA 99, Health Care Facilities Code. The failure to store helium as required may result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. The findings were: Observation on 01/27/2023 at 3:41 PM in the kitchen by the soda syrup stack revealed four (4) cylinders of carbon dioxide that were unsecured and on the floor. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99: Sections 11.3.2.6,	K 923	<u>K-923</u> <u>SS=D</u> <u>Gas Equipment - Cylinder and Container Storage</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced by:</u> Based on observation and staff interview, the facility failed to store helium in accordance with the 2012 NFPA 99, Health Care Facilities Code. The failure to store helium as required may result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. Observation on 01/27/2023 at 3:41 PM in the kitchen by the soda syrup stack revealed four (4) cylinders of carbon dioxide that were unsecured and on the floor. <u>Corrective Action(s):</u> The Facility Operations Manager or designee secured all carbon dioxide tank cylinders with a chain. The deficiency was corrected immediately upon discovery. <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.	03/14/2025	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05 B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC			STREET ADDRESS, CITY, STATE, ZIP CODE 8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520		
(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	
K 923	Continued From page 7	K 923	<u>K-923 (Con't)</u>		
K 000	INITIAL COMMENTS	K 000	<u>SS=D</u> <u>Gas Equipment - Cylinder and</u> <u>Container Storage</u> <u>CFR(s): NFPA 101</u>		
	A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25.		Responsible Person(s): The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved.		
	Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, New Health Care, of the National Fire Protection Association.		The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 000	INITIAL COMMENTS	K 000			
	A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25.				
	Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, New Health Care, of the National Fire Protection Association.				
	The facility was a fully sprinklered, single-story building of Type II(000) construction built in 2022. The building was equipped with a supervised, automatic wet sprinkler system with a zoned fire alarm system. The overall campus had a capacity of 20 certified beds with a census of 12 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.				
K 000	INITIAL COMMENTS	K 000			
	A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25.				
	Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, New Health Care, of the National Fire Protection Association.				
	The facility was a fully sprinklered, single-story building of Type II(000) construction built in 2022. The building was equipped with a supervised,				

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K 000	Continued From page 8 automatic wet sprinkler system with a zoned fire alarm system. The overall campus had a capacity of 20 certified beds with a census of 12 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000	K-100 SS=D General Requirements - Other CFR(s): NFPA 101 <u>This STANDARD is not met as evidenced</u> <u>by:</u> Based on observation and staff interview, the facility failed to maintain equipment in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain equipment as required could delay egress resulting in injury or death during an emergency. The deficiency affected one attic hatch throughout the facility.		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25. Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, New Assembly, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type II(000) construction built in 2022. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The overall campus had a capacity of 20 certified beds with a census of 12 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000	Observation on 01/27/25 at 4:35 PM in the female swim locker room/showers revealed an attic hatch left in an open position exposing the attic space to the potential passage of fire and smoke. <u>Corrective Action(s):</u> The Facility Operations Manager or designee shut the attic hatch. The deficiency was corrected immediately upon discovery.	03/14/2025	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/27/25 though 01/28/25. Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the	K 000	<u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.		

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K 000	Continued From page 9 applicable provisions of the 2012 Edition of the Life Safety Code, New Assembly, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type II(000) construction built in 2022. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The overall campus had a capacity of 20 certified beds with a census of 12 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000	<u>K-100 (Con't)</u> <u>SS=D</u> <u>General Requirements - Other</u> <u>CFR(s): NFPA 101</u> <u>Responsible Person(s)</u> : The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 100 SS=D	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 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 equipment in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain equipment as required could delay egress resulting in injury or death during an emergency. The deficiency affected one attic hatch throughout the facility. The findings were: Observation on 01/27/25 at 4:35 PM in the female swim locker room/showers revealed an attic hatch left in an open position exposing the attic space to the potential passage of fire and smoke. Interview with the facility staff at the time of	K 100			

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K 100	Continued From page 10 observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 4.6.12.1	K 100	<u>K-271 (Crescent Wing)</u> <u>SS=E</u> <u>Discharge From Exits</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced</u> <u>by:</u> Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. Observation 1/27/2025 at 5:07PM at the north exit, and on 1/27/2025 at 5:16PM the exit discharge from the west building exit.		
K 271 SS=E	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. The findings were: Observation on 01/27/25 at 5:07 PM at the north exit from the circular building portion revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 5:16 PM revealed that the exit discharge from the west building exit would require traversing through a similarly blocked section of sidewalk to the public way.	K 271	Observation on 01/27/25 at 5:07 PM at the north exit from the circular building portion revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 5:16 PM revealed that the exit discharge from the west building exit would require traversing through a similarly blocked section of sidewalk to the public way. <u>Corrective Action(s):</u> Operations staff cleared the sidewalks at the north and west exits of snow and ice. The deficiency was corrected immediately upon discovery.	03/14/2025	

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K 100	Continued From page 10 observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 4.6.12.1	K 100	<u>K-271 (Con't)</u> <u>SS=E</u> <u>Discharge From Exits</u> <u>CFR(s): NFPA 101</u>		
K 271 SS=E	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. The findings were: Observation on 01/27/25 at 5:07 PM at the north exit from the circular building portion revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 5:16 PM revealed that the exit discharge from the west building exit would require traversing through a similarly blocked section of sidewalk to the public way.	K 271	<u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		

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K 271	Continued From page 11 Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections: 18.2.1, 18.2.7, 18.7.3.1; 7.1.10.1, 7.1.6.4	K 271	<u>K-271 (Rec Center)</u> <u>SS=E</u> <u>Discharge From Exits</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced</u> <u>by:</u> Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. Observation 1/27/2025 at 4:26PM from the pool room and on 1/27/2025 at 4:39PM at the exit discharge from the basketball gym.		
K 271 SS=E	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. The findings were: Observation on 01/27/25 at 4:26 PM at the exit from the pool room revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 4:39 PM revealed that the exit discharge from the basketball gym would require traversing through a similarly blocked section of sidewalk to the	K 271	Observation on 01/27/25 at 4:26 PM at the exit from the pool room revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 4:39 PM revealed that the exit discharge from the basketball gym would require traversing through a similarly blocked section of sidewalk to the public way. <u>Corrective Action(s):</u> Operations staff cleared the sidewalks at the pool room and gym exits of snow and ice. The deficiency was corrected immediately upon discovery.	03/14/2025	

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K 271	Continued From page 11 Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections: 18.2.1, 18.2.7, 18.7.3.1; 7.1.10.1, 7.1.6.4	K 271	<u>K-271 (Con't)</u> <u>SS=E</u> <u>Discharge From Exits</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.		
K 271 SS=E	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges from the building. The findings were: Observation on 01/27/25 at 4:26 PM at the exit from the pool room revealed that the sidewalk to the public way was obstructed by more than an inch of snow. Further observation on 01/27/25 at 4:39 PM revealed that the exit discharge from the basketball gym would require traversing through a similarly blocked section of sidewalk to the	K 271	<u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		

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K 271	Continued From page 12 public way. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. . REF: 2012 NFPA 101, Sections: 12.2.1, 12.2.7.1, 12.7.1.1; 7.1.10.1, 7.1.6.4	K 271	<u>K-291</u> <u>(Kitchen, Crescent Wing, Rec Center, Sunflower,</u> <u>Sapphire)</u> <u>SS=F</u> <u>Emergency Lighting</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced</u> <u>by:</u> Based on observation and staff interview, the facility failed to provide emergency lighting testing in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility.		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting testing in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, and no documentation was provided that confirmed a 90 minute annual test. Interview with the facility staff at the time of observation acknowledged the deficiency, and	K 291	Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, and no documentation was provided that confirmed a 90-minute annual test. REF: 2012 NFPA 101, Section: 18.2.9.1, 7.9 <u>Corrective Action(s):</u> The Facility Operations Manager or designee will conduct monthly thirty (30) second and annual ninety (90) minute testing on the emergency lighting appliances. All testing will be documented for record-keeping purposes.	03/14/2025	

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K 291	Continued From page 13 indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section: 18.2.9.1, 7.9	K 291	<u>K-291 (Con't)</u> <u>SS=F</u> <u>Emergency Lighting</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve event detection, optimize cause analysis, and build best practices. The committee will also review and address any compliance issues.		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting testing in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, and no documentation was provided that confirmed a 90 minute annual test. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 291			

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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	
K 291	Continued From page 15 Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting testing in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting testing as required could result in injury or death during an emergency. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document Review on 01/28/2025 starting at 8:00 AM revealed that the facility provided records showing testing was performed monthly for June, August, September, October, November, and December, and no documentation was provided that confirmed a 90 minute annual test. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 291	<u>K-293</u> <u>SS=D</u> <u>Exit Signage</u> <u>CFR(s): NFPA 101</u> <u>This STANDARD is not met as evidenced by:</u> Based on observation and staff interview, the facility failed to maintain exit signage in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress exit signs as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one exit discharge from the building's south. Observation on 01/27/25 at 5:03 PM at the south exit in the ring portion of the building revealed that an exit sign was present above a closed and blocked door. Door was closed and blocked for a construction project, and no interim life safety measure was provided. <u>Corrective Action(s):</u> Operations staff covered the exit sign to indicate that the door was not an available exit while construction continued. The deficiency was corrected immediately upon discovery.	03/14/2025	
K 293 SS=D	REF: 2012 NFPA 101, Section: 12.2.9.1, 7.9 Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	K 293	<u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.		

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K 293	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signage in accordance with the NFPA 101, Life Safety Code. Failure to maintain means of egress exit signs as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one exit discharge from the building's south. The findings were: Observation on 01/27/25 at 5:03 PM at the south exit in the ring portion of the building revealed that an exit sign was present above a closed and blocked door. Door was closed and blocked for a construction project, and no interim life safety measure was provided. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 293	<u>K-293 (Con't)</u> <u>SS=D</u> <u>Exit Signage</u> <u>CFR(s): NFPA 101</u> Responsible Person(s): The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 321 SS=D	REF. 2012 NFPA 101, Sections 12.4.7.7.1, 7.10 Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler	K 321			

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K 321	Continued From page 17 system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 1010, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 1/29/25 at 10:55 AM in the storage room 106 revealed it was storing clean linen. The storage room by plan is 51 sqft, and the door was equipped with a closure but when dropped the door failed to shut and latch. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement.	K 321	<u>K-321</u> <u>SS=D</u> <u>Hazardous Areas - Enclosure</u> <u>CFR(s): NFPA 101</u> This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 1010, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. Observation on 1/29/25 at 10:55 AM in the storage room 106 revealed it was storing clean linen. The storage room by plan is 51 sq ft, and the door was equipped with a closure but when dropped the door failed to shut and latch. <u>Corrective Action(s):</u> Storage room 106 surface mount door closure was adjusted to increase latching speed so that the door would close and latch. The deficiency was corrected immediately upon discovery. <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.	03/14/2025

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K 321	Continued From page 17 system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 1010, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 1/29/25 at 10:55 AM in the storage room 106 revealed it was storing clean linen. The storage room by plan is 51 sqft, and the door was equipped with a closure but when dropped the door failed to shut and latch. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement.	K 321	<u>K-321 (Con't)</u> <u>SS=D</u> <u>Hazardous Areas - Enclosure</u> <u>CFR(s): NFPA 101</u> Responsible Person(s): The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		

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K 321	Continued From page 18	K 321	<u>K-345</u> <u>(Kitchen, Crescent, Rec Center, Sunflower,</u> <u>Sapphire)</u> <u>SS=F</u> <u>Fire Alarm System – Testing and</u> <u>Maintenance</u> <u>CFR(s): NFPA 101</u>		
K 345 SS=F	Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 Sections 18.3.2.1; 18.3.6.3.11 Table 18.3.2.1 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 test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was: Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within	K 345	<u>This STANDARD is not met as evidenced by:</u> Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. Document review on 1/28/25 starting at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. The facility provided documentation demonstrating battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. <u>Corrective Action(s):</u> The Facility Operations Manager or designee will conduct a fire alarm battery inspection every six (6) months. All inspections and testing will be documented for record-keeping purposes.	03/14/2025	

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K 345	Continued From page 19 the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not 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) K 345 Fire Alarm System - Testing and Maintenance SS=F 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 test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was: Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are	K 345	<u>K-345 (Con't)</u> <u>SS=F</u> <u>Fire Alarm System – Testing and</u> <u>Maintenance</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		

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K 345	Continued From page 20 required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not 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)	K 345			
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 test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was:	K 345			

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K 345	Continued From page 21 Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 345			
K 345 SS=F	REF: 2010 NFPA 72 Table 14.3.1(3)(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 test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code, Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire.	K 345			

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K 345	Continued From page 22 The deficiency had the potential to impact all residents, staff, and visitors within the facility. The finding was: Document review on 1/28/25 starting at at 8:00 AM revealed that the fire alarm system batteries were inspected once in the last twelve (12) months. The fire alarm system batteries are required to be inspected every six (6) months. Facility provided documentation demonstrated battery testing during the annual inspections, but no additional testing could be established within the past twelve (12) months. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	K 345	<u>K-351</u> <u>SS=D</u> <u>Sprinkler System - Installation</u> <u>CFR(s): NFPA 101</u> This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous sprinkler heads throughout the facility. Observation on 1/28/2022 at 11:07 AM in the medication office 123A revealed a fire sprinkler head with the escutcheon missing, exposing the annual space.	03/14/2025	
K 351 SS=D	REF: 2010 NFPA 72 Table 14.3.1(3)(d) Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the 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 and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms.	K 351	<u>Corrective Action(s):</u> Operations staff replaced the fire sprinkler escutcheon around the sprinkler head. The deficiency was corrected immediately upon discovery. <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction.		

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K 351	Continued From page 23 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous sprinkler heads throughout the facility. The findings were: Observation on 1/28/2022 at 11:07 AM in the medication office 123A revealed a fire sprinkler head with the escutcheon missing, exposing the annual space. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101: Section 18.3.5.1, 9.7.1.1(1) 2010 NFPA 13: Section 6.2.7.1	K 351	<u>K-351 (Con't)</u> <u>SS=D</u> <u>Sprinkler System - Installation</u> <u>CFR(s): NFPA 101</u> Responsible Person(s): The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review and address any compliance issues.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918			

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC			STREET ADDRESS, CITY, STATE, ZIP CODE 8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520		
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K 918	Continued From page 24 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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	K 918	<u>K-918</u> <u>(Kitchen, Crescent, Rec Center, Sunflower, Sapphire)</u> <u>SS=F</u> <u>Electrical Systems – Essential Electric System</u> <u>CFR(s): NFPA 101</u> This STANDARD 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 had the potential to impact all residents, staff, and visitors within the facility. Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. 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. <u>Corrective Action(s):</u> The Facility Operations Manager or designee will create an established program for inspecting and exercising electrical components in accordance with the manufacturer's recommendations. Main	03/14/2025	

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K 918	Continued From page 25 maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. 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 the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99, Section 10.4.4.1.2	K 918	<u>K-918 (Con't)</u> <u>SS=F</u> <u>Electrical Systems – Essential Electric System</u> <u>CFR(s): NFPA 101</u> and feeder circuit breakers will be inspected annually, and a program for periodically exercising the components shall be established according to manufacturer's recommendations All inspections and exercising and program development will be documented for record-keeping purposes. <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve event detection, optimize cause analysis, and build best practices. The committee will also review and address any compliance issues.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918			

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K 918	Continued From page 26 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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, Health Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with	K 918			

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K 918	Continued From page 27 manufacturer's recommendations. 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 the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99, Section 10.4.4.1.2	K 918			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918			

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K 918	Continued From page 28 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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, Health Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. 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 the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement.	K 918			

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K 918	Continued From page 29 Interview with the facility administrator at the time of exit confirmed the deficiency.	K 918			
K 918 SS=F	Ref: 2012 NFPA 99, Section 10.4.4.1.2 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918			

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K 918	Continued From page 30 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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 had the potential to impact all residents, staff, and visitors within the facility. The findings were: Document review on 1/28/2025 starting at 8:00 AM revealed the facility did not have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations. 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 the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99, Section 10.4.4.1.2	K 918			
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923			

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K 923	Continued From page 31 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store oxygen when over 300 cubic feet in a storage area in accordance	K 923	<u>K-923</u> <u>Gas Equipment - Cylinder and Container Storage</u> <u>CFR(s): NFPA 101</u> This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store oxygen when over 300 cubic feet in a storage area in accordance with the 2012 NFPA 99, Standard for Health Care Facilities. Failure to properly store oxygen could lead to injury or death during an emergency. The deficiency affected one (1) of multiple storage rooms. Observation on 1/28/2025 at 10:34 AM in the clean storage room revealed: 15 E size cylinders totaling approximately 375 cu ft, and on top of vinyl flooring. The room itself contained combustible storage including combustible items within 5 ft. The door of the storage room failed to indicate that it was being used for oxygen storage. Corrective Action(s): The Facility Operations Manager or designee will ensure room is free of combustible items within 5 ft of cylinders. Proper signage indicating oxygen storage will be installed.	03/14/2025	

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K 923	Continued From page 32 with the 2012 NFPA 99, Standard for Health Care Facilities. Failure to properly store oxygen could lead to injury or death during an emergency. The deficiency affected one (1) of multiple storage rooms. The findings were: Observation on 1/28/2025 at 10:34 AM in the clean storage room revealed: 15 E size cylinders totaling approximately 375 cu ft, and on top of vinyl flooring. The room itself contained combustible storage including combustible items within 5 ft. The door of the storage room failed to indicate that it was being used for oxygen storage. Interview with the facility staff at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99, Sections: 11.3.2.3(2); 11.3.4.1	K 923	<u>K-923 (Con't)</u> <u>Gas Equipment - Cylinder and Container Storage</u> <u>CFR(s): NFPA 101</u> <u>Monitoring and Tracking:</u> The Facility Operations Manager will ensure the completion of this correction plan and provide documentation evidence proof of correction. <u>Responsible Person(s):</u> The results of the corrections will be reported by the Facility Operations Manager to the SNF - Quality Assurance Performance Improvement Committee (SNF-QAPI) as corrections are resolved. The SNF Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve event detection, optimize cause analysis, and build best practices. The committee will also review and address any compliance issues.		