STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 07/24/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a complete communication plan in the Emergency Preparedness Plan (EPP) as required in accordance with 483.73(c). Failure to provide a complete communication plan could result in an inadequate ability to communicate with staff, emergency officials, entities providing services, other facilities, and the community. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 1:30 PM revealed that the facility failed to provide all	E 029		

Meredith ADMINISTRATOR 8-29-24

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

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

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E 029	Continued From page 1 required elements of a communication plan. At the time of the survey no documentation was available to demonstrate that the facility had phone numbers for entities providing services. Interview with administrative staff at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	E 029	E 029 Corrective action was taken and accomplished by adding contact information for all entities providing services in Facility Disaster plan Under Appendix B. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event that proper contact information is not available. The facility will review and update Facility Disaster Plan annually. Plan will be updated as needed as contact information changes as to ensure communication. Discussion, Review, and revision, of Life Safety Code E029 shall take place in future Quality Assurance Performance Improvement meetings. (QAPI)	Completed on 8/8/2024 Ongoing reviews and updates to facility contacts Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 2 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency	E 037		

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E 037	Continued From page 3 preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 4 least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on document review and staff interview, the facility failed to conduct training of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(1). Failure to conduct training of the EPP could result in inadequate preparedness of staff in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors.

The findings were:

Document review on 07/24/24 starting at 1:30 PM revealed that the facility failed to train staff on

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E 037	Continued From page 6 EPP. At the time of the survey no documentation was available to demonstrate that the facility had conducted initial training of the EPP with staff, or the annual training with staff. The facility shall provide initial training to new staff on the EPP and annual training to all staff. Documentation of training shall be maintained, and a demonstration of staff knowledge shall be provided. Interview with administrative staff at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	E 037	E 037 Corrective action was taken and accomplished by implementing Emergency/Disaster Training immediately upon understanding the requirements. Upon hire, staff will receive initial training on facility EPP. Additionally, annual training will be provided to all staff. Documentation will be maintained to ensure all staff receive training. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event that proper training did not occur and was therefore not documented regarding emergency/disaster. The facility EPP will be reviewed and updated annually and as needed. The facility will update training material as necessary to provide current procedures in emergency situations. Discussion, Review, and revision, of Life Safety Code E037 shall take place in future Quality Assurance Performance Improvement meetings. (QAPI)	Completed 7/25/2024 Continue updates for training agendas. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or	E 039		

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E 039	Continued From page 7 (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or	E 039		

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E 039	Continued From page 8 man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 9 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 10 (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 11 (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or	E 039		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

E 039	Continued From page 12 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements,	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 039	Continued From page 13 directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 14 questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

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E 039	Continued From page 15 emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct testing of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(2). Failure to conduct testing of the EPP could result in inadequate execution of the EPP and collaboration with the community in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 1:30 PM revealed that the facility failed to conduct all required testing of the EPP. At the time of the survey documentation was available to demonstrate that the facility had conducted a table top exercise in February of 2024. No additional documentation was available to demonstrate that the facility participated in a full-scale exercise with the community, or that the facility experienced an emergency that required activation of the emergency plan. Interview with administrative staff at the time of observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	E 039	E 039 Immediate corrective action was taken to join the Wyoming Health Care Coalition as well as the Johnson County Emergency Management System. A memorandum of understanding has been completed for sheltering agreement for our residents in an emergency. VHW staff are now attending scheduled meetings. A future community based emergency drill has been requested and is scheduled for October 2024. It should be noted that a table top emergency exercise was conducted with staff 2/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in that proper testing of the emergency preparedness plan was not done. Ongoing participation within the emergency management systems continue. The importance of community based drills will also be disseminated to local emergency management systems. Continue to conduct Table Top Emergency training as appropriate. Discussion, Review, and revision, of Life Safety Code E039 shall take place in future Quality Assurance meetings.	Completed on 8/1/2024 Participation in emergency coalition meetings to take place monthly Discussed and Reviewed EPP at QAPI Meeting 8/27/2024.
E 041 SS=F	Hospital CAH and LTC Emergency Power	E 041		

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E 041	Continued From page 16 CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	E 041		

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E 041	Continued From page 17 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to	E 041		

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E 041	Continued From page 18 NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect, test, and maintain the essential electrical system (EES) in accordance with §483.73(e). Failure to inspect, test, and maintain the EES could result in a malfunction of the EES in the event of a power outage. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. No documentation was available at the time of the survey to provide evidence from the natural gas provider for the reliability of the natural gas service.	E 041	E 041 Corrective action was immediately taken to secure proof of low probability of interruption of Natural Gas by the Montana-Dakota Utilities CO. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a gas interruption. Facility has now gained proof of low interruption. Annual follow-up shall occur to maintain updated documentation of low probability of service interruption. Discussion, Review, and revision, of Life Safety Code E041 shall take place in future Quality Assurance meetings.	Completed/letter received on 8/7/2024. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

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E 041	Continued From page 19 Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 110 5.1.4	E 041		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/24/2024. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this 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, one-story building, with a mechanical equipment crawlspace, of Type II (000) construction built in 2023. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 0 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/24/2024. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise	K 000		

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K 000	Continued From page 20 provided in this 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, one-story building, with a mechanical equipment crawlspace, of Type II (000) construction built in 2023. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 8 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/24/2024. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this 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, one-story building, with a mechanical equipment crawlspace, of Type II (000) construction built in 2023. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 10 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 345	Fire Alarm System - Testing and Maintenance	K 345		

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K 345	Continued From page 21	K 345		

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 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to perform all required annual and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the annual testing of the fire alarm system was conducted, but no record was included to demonstrate that the alarm notification devices were included in the annual testing. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested once in the last twelve (12) months. No additional documentation was	K 345 The Veteran's Home of Wyoming took immediate corrective action in testing scheduling alarm notification devices. Further documentation acquired after the survey from Western States Fire Protection CO. is included which addressed the testing of alarm notification devices. The testing took place between 5/24/2024 and 5/26/2024. An additional inspection has also been scheduled for Friday, 8/30/2024 to address testing of alarm notification devices. Furthermore, battery testing and documentation has begun bi-annually. A battery tester was acquired 8/26/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual follow-up shall occur and be documented to maintain updated testing of alarm notification devices. Bi-annual testing of fire alarm system batteries shall be documented. Discussion, Review, and revision, of Life Safety Code K345 shall take place in future Quality Assurance meetings.	Projected completion date 8/30/2024 confirmed in schedule by Western States Fire Protection CO. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

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K 345	Continued From page 22 available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(20), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	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 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and could potentially affect all residents, staff, and visitors.	K 345		

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K 345	Continued From page 23 The findings were: HERE Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to perform all required annual and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the annual testing of the fire alarm system was conducted, but no record was included to demonstrate that the alarm notification devices were included in the annual testing. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested once in the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(20), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	K 345 The Veteran's Home of Wyoming took immediate corrective action in testing scheduling alarm notification devices. Western States Fire Protection CO. is currently working to schedule an inspection. Furthermore, battery testing and documentation has begun bi-annually. A battery tester was acquired 8/26/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual follow-up shall occur and be documented to maintain updated testing of alarm notification devices. Bi-annual testing of fire alarm system batteries shall be documented. Discussion, Review, and revision, of Life Safety Code K345 shall take place in future Quality Assurance meetings.	Projected completion date 8/30/2024 confirmed in schedule by Western States Fire Protection CO. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.
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	K 345		

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	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 345	Continued From page 24 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 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to perform all required annual and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the annual testing of the fire alarm system was conducted, but no record was included to demonstrate that the alarm notification devices were included in the annual testing. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested once in the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(20), Table	K 345	K 345 The Veteran's Home of Wyoming took immediate corrective action in scheduling alarm notification devices to be tested. Western States Fire Protection CO. is currently working to schedule an inspection. Furthermore, battery testing and documentation has begun bi-annually. A battery tester was acquired 8/26/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual follow-up shall occur and be documented to maintain updated testing of alarm notification devices. Bi-annual testing of fire alarm system batteries shall be documented. Discussion, Review, and revision, of Life Safety Code K345 shall take place in future Quality Assurance meetings.	Projected completion date 8/30/2024 confirmed by Western States Fire Protection CO. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 345	Continued From page 25 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire dampers could result in the spread of smoke and fire, which could result in injury or death. The deficiency affected the HVAC system, and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to conduct the required inspection and testing of the fire dampers. No documentation was available at the time of the survey to demonstrate that the one (1) year inspection and testing of the fire dampers was conducted. Fire dampers shall be inspected and tested one (1) year after the installation of the fire dampers.	K 521	K521 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire dampers in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire dampers shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K521 shall take place in future Quality Assurance meetings.	Completed on 8/22/2024. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 521	Continued From page 26 Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 18.5.2.1, 9.2.1; 2012 NFPA 90A 5.4.8; 2010 NFPA 80 19.4.1	K 521		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire dampers could result in the spread of smoke and fire, which could result in injury or death. The deficiency affected the HVAC system, and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to conduct the	K 521		

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 521	Continued From page 27 required inspection and testing of the fire dampers. No documentation was available at the time of the survey to demonstrate that the one (1) year inspection and testing of the fire dampers was conducted. Fire dampers shall be inspected and tested one (1) year after the installation of the fire dampers. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 18.5.2.1, 9.2.1; 2012 NFPA 90A 5.4.8; 2010 NFPA 80 19.4.1	K 521	K 521 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire dampers in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire dampers shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K521 shall take place in future Quality Assurance meetings.	Completed 8/22/2024 Discussed and Reviewed EPP at QAPI meeting 8/27/2024.
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire dampers could result in the spread of smoke and fire, which could result in injury or death. The	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 521	Continued From page 28 deficiency affected the HVAC system, and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to conduct the required inspection and testing of the fire dampers. No documentation was available at the time of the survey to demonstrate that the one (1) year inspection and testing of the fire dampers was conducted. Fire dampers shall be inspected and tested one (1) year after the installation of the fire dampers. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 18.5.2.1, 9.2.1; 2012 NFPA 90A 5.4.8; 2010 NFPA 80 19.4.1	K 521	K 521 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire dampers in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire dampers shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K521 shall take place in future Quality Assurance meetings.	Completed on 8/22/2024 Discussed and Reviewed EPP at QAPI meeting 8/27/2024.
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience	K 761		

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

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K 761	Continued From page 29 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire doors could result in the spread of smoke and fire, which could result in injury or death. The deficiency affected all rated fire doors, and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to conduct the required inspection and testing of the fire doors. No documentation was available at the time of the survey to demonstrate that the annual fire door inspection and testing had been conducted in the last twelve (12) months. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	K 761 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire doors in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire doors shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K761 shall take place in future Quality Assurance meetings.	Completed on 8/22/2024 Discussed and Reviewed EPP at QAPI meeting 8/27/2024.
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 761	Continued From page 30 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire doors could result in the spread of smoke and fire, which could result in injury or death. The deficiency affected all rated fire doors, and had the potential to affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to conduct the required inspection and testing of the fire doors. No documentation was available at the time of the survey to demonstrate that the annual fire door inspection and testing had been conducted in the last twelve (12) months. Interview with the maintenance supervisor at the	K 761	K 761 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire doors in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire doors shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K761 shall take place in future Quality Assurance meetings.	Completed on 8/22/2024 Discussed and Reviewed EPP at QAPI meeting 8/27/2024.

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	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
	700 VETERANS' LANE

WYOMING VETERANS' SKILLED NURSING FACILITY	BUFFALO, WY 82834

(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 761	Continued From page 31 time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain fire doors could result in the spread of smoke and fire, which could result in injury or death. The deficiency affected all rated fire doors, and had the potential to affect all residents, staff, and visitors.	K 761		

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

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K 761	Continued From page 32 The findings were: Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to conduct the required inspection and testing of the fire doors. No documentation was available at the time of the survey to demonstrate that the annual fire door inspection and testing had been conducted in the last twelve (12) months. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	K 761 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and testing of the fire doors in each of the three cottages. The testing was completed by the State Fire Marshal on 8/22/2024. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a fire emergency. Annual inspections of the fire doors shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K761 shall take place in future Quality Assurance meetings.	Completed on 8/22/2024. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.
K 918 SS=F	Electrical Systems - Essential Electric System 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	K 918		

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WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

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K 918	Continued From page 33 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 test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiencies affected the EES, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to test the emergency electrical generator lead-acid batteries as required. No documentation was available at the time of the survey to demonstrate	K 918	K 918 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and conductance testing of the electrical generator lead-acid batteries. The testing was completed by VHW maintenance staff on 8/27/2024. Discussed and reviewed K918 in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a power failure. Monthly inspections of the electrical generator lead-acid battery conductance shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K918 shall take place in future Quality Assurance meetings.	Completed 8/27/2024 Discussed and ReviewedK918 at QAPI meeting 8/27/2024.

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K 918	Continued From page 34 that the conductance test was being conducted on the emergency electrical generator batteries. Lead-acid batteries associated with the emergency electrical generator shall be tested monthly for conductance. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.3.7.1 Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. No documentation was available at the time of the survey to provide evidence from the natural gas provider for the reliability of the natural gas service. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 110 5.1.1 Ex.1	K 918		
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	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 918	Continued From page 35 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 test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 918	Continued From page 36 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiencies affected the EES, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to test the emergency electrical generator lead-acid batteries as required. No documentation was available at the time of the survey to demonstrate that the conductance test was being conducted on the emergency electrical generator batteries. Lead-acid batteries associated with the emergency electrical generator shall be tested monthly for conductance. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.3.7.1 Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. No documentation was available at the time of the survey to provide evidence from the natural gas provider for the reliability of the	K 918	K 918 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and conductance testing of the electrical generator lead-acid batteries. The testing was completed by VHW maintenance staff on 8/27/2024. Discussed and reviewed K918 in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a power failure. Monthly inspections of the electrical generator lead-acid battery conductance shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K918 shall take place in future Quality Assurance meetings.	Completed on 8/27/2024. Discussed and ReviewedK918 at QAPI meeting 8/27/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9071	A. BUILDING 01, 02, 03 B. WING _____	07/24/2024

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K 918	Continued From page 37 natural gas service. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 110 5.1.1 Ex.1 Electrical Systems - Essential Electric System 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	K 918		
K 918 SS=F		K 918		

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K 918	Continued From page 38 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 test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiencies affected the EES, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 07/24/24 starting at 12:30 PM revealed the facility failed to test the emergency electrical generator lead-acid batteries as required. No documentation was available at the time of the survey to demonstrate that the conductance test was being conducted on the emergency electrical generator batteries. Lead-acid batteries associated with the emergency electrical generator shall be tested monthly for conductance. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement.	K 918	K 918 The Veteran's Home of Wyoming took immediate corrective action in completing inspection and conductance testing of the electrical generator lead-acid batteries. The testing was completed by VHW maintenance staff on 8/27/2024. Discussed and reviewed K918 in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a power failure. Monthly inspections of the electrical generator lead-acid battery conductance shall occur and be documented. Discussion, Review, and revision, of Life Safety Code K918 shall take place in future Quality Assurance meetings.	Completed on 8/27/2024 Discussed and ReviewedK918 at QAPI meeting 8/27/2024.

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 918	Continued From page 39 Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.3.7.1 Document review on 07/24/24 starting at 12:30 PM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. No documentation was available at the time of the survey to provide evidence from the natural gas provider for the reliability of the natural gas service. Interview with the maintenance supervisor at the time of observation confirmed the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 110 5.1.1 Ex.1	K 918	Corrective action was immediately taken to secure proof of low probability of interruption of Natural Gas by the Montana-Dakota Utilities CO. Discussed and reviewed EPP in QAPI meeting 8/27/2024. The Veterans' Home of Wyoming acknowledges that this deficiency could negatively impact residents in the event of a gas interruption. Facility has now gained proof of low interruption. Annual follow-up shall occur to maintain updated documentation of low probability of service interruption. Discussion, Review, and revision, of Life Safety Code E041 shall take place in future Quality Assurance meetings.	Completed/letter received on 8/7/2024. Discussed and Reviewed EPP at QAPI meeting 8/27/2024.