STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HUNTER HOLLOW	4090 WEST PIONEER PARKWAY WEST VALLEY CITY, UT 84120

(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
F 000	INITIAL COMMENTS A Recertification Survey was completed from 01/08/2024 to 01/11/2024. The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000	**It is the practice of this facility to provide care/services for highest well-being in accordance with State and Federal law.**	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to assess 1 (Resident #74) of 10 sampled residents to ensure the resident was safe to self-administer inhaled medications. Finding included: A review of a facility policy titled, "Resident Self-Administration of Medication," revised in June 2023, revealed, "It is the policy of this facility to support the resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely." The policy revealed "1. Each resident is offered the opportunity to self-administer medications during routine assessment by the facility's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the	F 554 PoC Accepted GB 1/31/2024	**F554 – Resident Self-Admin Meds Clinically Appropriate** **Address how the Deficiency will be resolved:** 1. Director of Nursing interviewed resident #74 regarding his desire for self-administration of rescue inhaler. Resident requested the inhaler to remain in his room. The following was completed for Resident #74: A self-administration observation was updated to reflect change, obtained physician order for self-administration, self-administration medication care plan was updated, placed a lock box in resident's room to secure medication, and verified supply of inhaler was reordered from pharmacy. 2. An immediate sweep of resident rooms was conducted by Director of Nursing and Unit Managers to ensure there were no additional unsecured medications at bedside unless the self-administer medications policy/procedure had been implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 1/30/24

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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F 554	Continued From page 1 interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when medications need to be taken; e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff. f. The resident's ability to understand what refusal of medications, and the appropriate steps taken by staff to educate when this occurs. g. The resident's ability to ensure that medication is stored safely and securely." The policy also revealed "12. The care plan must reflect resident self-administration and storage arrangements for such medications. During an interview on 01/09/2024 at 2:27 PM, the Director of Nursing (DON) stated the facility did not have any residents who were allowed to self-administer medications or inhalers. She stated the facility had a policy that prohibited residents to keep medicines and inhalers in their rooms. A review of Resident #74's "Resident Face Sheet" revealed the facility admitted Resident #74 on 12/03/2023. The resident had diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, shortness of breath-air hunger, and dependence on supplemental oxygen.	F 554	3. Residents with order for inhaler have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. 4. All staff were educated on the requirements of self-administration of medication; specifically, the nursing staff on the importance of completing the self-administration observation if applicable before any resident self-administers medication, this includes leaving medications at bedside for residents to take at a later time. On-going monitoring of items in resident rooms by all staff to make sure items are secured in resident locked cabinet if applicable or in the medication cart. 5. The DON or designee will monitor all new admissions for self-administration assessment completion if appropriate. An environmental rounding tool was implemented, it includes checking the resident's rooms for any medications that should be secured. DON or designee will conduct this audit at random weekly times 4 weeks. Bi-monthly times 1 month. Monthly times 1 month. 6. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F 554	Continued From page 2 A review of Resident #74's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/2023, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderately impaired cognition. Per the MDS, the resident's vision and hearing were adequate. The MDS revealed the resident required setup or clean up assistance with oral hygiene and supervision or touching assistance with transfers and bed mobility. A review of Resident #74's "Care Plan" problem area, dated 12/03/2023, revealed the resident required respiratory support secondary to a history of subdural hematoma and chronic respiratory failure with hypoxia. The goal was for Resident #74 to have no unaddressed complications secondary to respiratory needs. The facility developed interventions that directed staff to monitor oxygen levels every shift and as needed and to administer oxygen as prescribed. Resident #74's Care Plan did not address the self-administration of medications. A review of Resident #74's physician "Active Orders" revealed an order dated 01/09/2024 for Ventolin HFA (albuterol sulfate was an inhaled medication used to treat spasms or narrowing of the airways in the lungs) two puffs every six hours as needed. Further review of the Active Orders revealed an order started on 12/05/2023 for budesonide suspension for nebulization (medication used to prevent asthma attacks), 0.5 milligram/2 milliliter inhalation, twice a day. On 01/09/2024 at 2:11 PM, Resident #74 was observed to have three inhalers labeled albuterol and one single dose ampule of budesonide on	F 554	**Adress who will be responsible for the correction of the Deficiency:** The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by February 16, 2024.	

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the bedside table. The resident stated the inhaler marked "12-14-23" indicated that was the date the nurse left the inhaler at the bedside. The resident stated they used the inhalers when they were short of breath. The resident stated nurses brought the resident the inhalers and no nurse was present when they self-administered the inhalers. The resident further stated they did not notify a nurse when the inhalers were self-administered.

On 01/10/2024 at 8:43 AM, during the medication administration pass with Licensed Practical Nurse (LPN) #10, an observation revealed Resident #74 had an inhaler on the bedside table. An interview with LPN #10 revealed she was aware Resident #74 kept inhalers at the bedside. However, she noted she was unaware of the facility's procedure for a resident to self-administer medications. She stated if a resident reported they had used an inhaler, she documented that she administered the medication but made a note that the resident reported the medication was self-administered. LPN #10 stated she did not know whether the resident was informing nurses when the inhalers were used. Further interview with the LPN revealed Resident #74 had a physician order to administer an inhaler but she did not see an order for the resident to self-administer medications. LPN #10 stated she did not know whether the facility had assessed the resident for self-administration of medications.

A review of Resident #74's January 2024 "Medication Administration Record [MAR]" revealed staff documented budesonide treatments were provided twice daily from 01/01/2024 through 10:00 AM on 01/11/2024. There was no note indicating the resident had

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self-administered the medication. Further review of the January 2024 MAR revealed staff documented an "X" for the albuterol inhaler from 01/09/2024 through 01/11/2024, and there was no indication the resident had self-administered the medication.

During an interview on 01/10/2024 at 8:50 AM, LPN #11 verbalized she was aware Resident #74 had inhalers at the bedside. She stated if the resident was alert and had a care plan, it was "okay" to have inhalers at the bedside. LPN #11 stated she did not know if a care plan for self-administration had been developed, if there was a physician order for self-administration, or if an assessment for the self-administration of medications had been conducted for Resident #74. She stated the resident was alert and could use the inhaler but did not know whether the resident notified nurses when the inhalers were used. She stated if the resident told a nurse they had used the inhaler, the nurse would sign off the medication and add a note that the resident had self-administered the inhaler.

During an interview on 01/10/2024 at 9:00 AM, the DON stated staff should have informed her that a resident was self-administering inhalers and nebulizer treatments. She stated that, in order for the resident to self-administrator medications, there should be a physician's order, an assessment, resident training, and a care plan, noting the inhalers should also be secured in a locked box.

During an interview on 01/10/2024 at 3:13 PM, the Administrator stated she would have expected staff to inform the DON about Resident #74 being allowed to keep inhalers/medicines at the bedside

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F 554	Continued From page 5 so the facility could initiate the proper procedures to allow the resident to safely self-administrator medications. During an interview on 01/11/2024 at 10:07 AM, the nurse practitioner stated she had not previously written an order for Resident #74 to self-administer inhalers.	F 554	**It is the practice of this facility to provide care/services for highest well-being in accordance with State and Federal law.**	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	**F656 – Develop/Implement Comprehensive Care Plan** **Address how the Deficiency will be resolved:** 1. The alleged deficiency occurred when the facility staff failed to address in respiratory care plan the care of tracheostomy or the use of an invasive mechanical ventilator. The respiratory care plan for resident #80 was immediately updated to include respiratory support vent/trach. 2. Director of Nursing audited all residents who have a respiratory care plan on the Trach/Vent unit to verify tracheostomy or use of mechanical ventilator is in place. 3. All residents on the Trach/Vent unit have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. 4. All nursing staff were educated on the requirements of the respiratory care plan to include	

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F 656	Continued From page 6 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to develop a care plan for 1 (Resident #80) of 7 sampled residents who were dependent on respiratory ventilators. Findings included: A review of a facility policy titled, "Comprehensive Care Plans," revised in June 2023, revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the residents' comprehensive assessment." An observation of Resident #80 on 01/08/2024 at 10:58 AM revealed the resident had a	F 656	tracheostomy/mechanical ventilator usage if applicable. 5. The DON/Designee updated the respiratory baseline care plan for all residents on the trach/vent unit to ensure the vent/trach specifics are in place. This new baseline care plan was added for all admissions to the trach/vent unit. 6. Respiratory therapist/DON/Designee will audit the care plan to verify tracheostomy or use of mechanical ventilator is in place. MDS nurse will be the third check to verify. 7. DON or designee will conduct a respiratory care plan audit at random weekly time 4 weeks. Bi-monthly times 1 month. Monthly times 1 month. 8. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. **Adress who will be responsible for the correction of the Deficiency:** The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by February 16, 2024.	

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tracheostomy and was utilizing a mechanical ventilator.

A review of Resident #80's "Face Sheet" revealed the facility admitted the resident on 06/11/2022. Per the Face Sheet, the resident had diagnoses that included acute respiratory failure, dependence on a respiratory ventilator, a tracheostomy (a surgical opening through the neck into the trachea to provide an airway to the lungs), and cognitive communication deficit.

A review of Resident #80's significant change Minimum Data Set (MDS), with an Assessment Reference Date of 08/25/2023, revealed the resident had severely impaired cognitive skills for daily decision making. Per the MDS, the resident was totally dependent on staff to provide activities of daily living (ADLs). The MDS also revealed Resident #80 was dependent on an invasive mechanical ventilator.

A review of Resident #80's physician "Orders" revealed orders, dated 08/18/2023, directing staff to conduct ventilator respiratory rounds every four hours, to change the ventilator as needed, and to provide ventilator weaning as needed. There were also physician orders, dated 06/11/2022, directing staff to provide tracheostomy care twice per day, change the tracheostomy supplies on the twenty-fifth of every third month, provide respiratory equipment/cleaning/maintenance on the tenth of every month, and to change all disposable respiratory supplies on the fifth of every month.

A review of Resident #80's "Care Plan," dated 03/25/2022, revealed Resident #80 required respiratory support secondary to acute respiratory

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F 656	Continued From page 8 failure and a tracheostomy. The listed goal was for the resident to have no unaddressed complications due to respiratory needs. The facility developed interventions that directed staff to monitor the resident's oxygen level, administer oxygen as prescribed, change the oxygen tubing and supplies as prescribed, and suction the resident airway as needed. There was no documented evidence the facility developed a care plan for Resident #80 that addressed the care of the resident's tracheostomy or the use of an invasive mechanical ventilator. During an interview on 01/10/2024 at 1:00 PM, MDS Coordinator #12 stated she and nursing staff were responsible for developing care plans. MDS Coordinator #12 stated nursing staff should have reported that Resident #80 was on a ventilator and a care plan should have been developed. During an interview on 01/10/2024 at 2:30 PM, the Director of Nursing (DON) stated a care plan had not been created for the use of a ventilator for Resident #80. During an interview on 01/10/2024 at 3:13 PM, the Administrator stated she expected staff to develop a care plan to address Resident #80's ventilator dependency.	F 656	**It is the practice of this facility to provide care/services for highest well-being in accordance with State and Federal law.**	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677	**F677 – ADL Care Provided for Dependent Residents** **Address how the Deficiency will be resolved:**	

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F 677	Continued From page 9 by: Based on observation, interview, record review, and policy review, the facility failed to provide nail care for 2 (Resident #76 and Resident #98) of 10 residents who were dependent on staff for personal hygiene. Findings included: A review of a facility policy titled, "Nail Care," revised June 2023, indicated, "4. Routine nail care, to include trimming and filing, will be provided on a regular schedule and as needed. Nail care will be provided between scheduled occasions as the need arises." 1. A review of Resident #76's "Resident Face Sheet" revealed the facility admitted the resident on 08/27/2022 with diagnoses that included dementia with other behavioral disturbance, anxiety, and need for assistance with personal care. A review of Resident #76's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/19/2023, revealed the resident could not complete a Brief Interview for Mental Status (BIMS) assessment. A Staff Assessment for Mental Status (SAMS) indicated the resident had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #76 required significant/maximum assistance with showering and required partial/moderate assistance with personal hygiene. A review of Resident #76's "Care Plan" problem area, dated 08/27/2022, revealed the resident was at risk for altered activities of daily living (ADL) function secondary to weakness and	F 677	1. Resident identified as: Resident #76 nails not trimmed. ADON immediately trimmed resident #76 nails and provided education to all nursing staff regarding proper nail care during ADL care. Resident #76 is receiving nail care per plan of care. 2. All residents receiving ADL care (specific to nail care) and dependent on staff for nail care have the potential to be affected for the same alleged deficient. No other residents were identified as being negatively impacted. 3. Immediate education was provided to all nursing/certified nursing assistants. 4. Education regarding proper nail care will be included as part of the certified nursing assistant orientation. 5. The DON/designee will audit through direct observation 5 random residents for ADL care with a focus on nail care. 6. The DON or designee will conduct this audit at random weekly time 4 weeks. Bi-monthly times 1 month. Monthly times 1 month. 7. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F 677	Continued From page 10 dementia. The facility developed care plan approaches that directed staff to assist the resident in completing ADL tasks each day. A review of Resident #76's "Shower Sheet/Skin Observation" forms revealed staff could choose "Yes" or "No" to answer whether the resident's nails had been clipped. The forms revealed staff documented "No" to indicate the resident's nails were not clipped on 12/11/2023, 12/20/2023, 12/22/2023, 12/27/2023, 01/03/2024, or 01/05/2024. The forms revealed staff did not document whether nail care was provided on 12/13/2023, 12/18/2023, 12/29/2023, 01/01/2024, 01/08/2024, or 01/10/2024. During a telephone interview on 01/08/2024 at 4:02 PM, Resident #76's family member stated Resident #76 was not aware of the need to complete personal hygiene tasks. The resident's family member expressed that staff needed to be more observant of Resident #76's personal hygiene. Resident #76's family member stated the resident's fingernails needed to be trimmed more frequently. Observation on 01/09/2024 at 12:21 PM revealed Resident #76 was in the dining room eating lunch. The observation revealed Resident #76's fingernails were long. The resident's right thumb nail was approximately one-fourth inch long. Observation on 01/10/2024 at 11:14 AM revealed Resident #76 sat in a hallway. Resident #76's fingernails continued to be long, with a light brown substance underneath the right thumb nail and right pointer finger nail. The resident stated they thought they received showering assistance that	F 677	**Adress who will be responsible for the correction of the Deficiency:** The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by February 16, 2024.	

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F 677	Continued From page 11 morning. During an interview on 01/10/2024 at 11:18 AM, Registered Nurse (RN) #1 stated Resident #76 received a shower that morning, noting she usually cut Resident #76's fingernails. RN #1 stated she had observed Resident #76's nails and identified they needed to be clipped. She stated she needed time to sit and talk to the resident when she cut the resident's nails but was discharging another resident at the time. RN #1 stated the certified nursing assistants (CNAs) could also cut Resident #76's fingernails. During an interview on 01/10/2024 at 1:25 PM, CNA #2 stated a nurse usually trimmed residents' fingernails but, if the CNAs had time, they could also trim them. CNA #2 stated that Resident #76 usually had long nails and it had probably been approximately two weeks since Resident #76's nails had been clipped. During an interview on 01/10/2024 at 1:43 PM, CNA #3 stated she offered to trim residents' fingernails when she provided showers if the resident did not have a diagnosis of diabetes. During an interview on 01/11/2024 at 8:56 AM, the Director of Nursing (DON) stated the Assistant Director of Nursing (ADON) was responsible for monitoring to ensure residents' nails were trimmed. The DON stated residents' nails should be trimmed on days the resident received a shower. The DON stated her expectation was for a resident's fingernails to be trimmed and cleaned and, if a resident refused nail trimming, it should be documented. During an interview on 01/11/2024 at 9:23 AM,	F 677		

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F 677	Continued From page 12	F 677		

the Administrator stated residents' fingernails should be trimmed on a consistent basis while respecting a resident's right to refuse. The Administrator stated if a resident refused nail care, it should be documented by staff.

2. A review of Resident #98's "Resident Face Sheet" revealed the facility admitted the resident on 12/01/2023 with diagnoses that included contracture of the muscle of the right upper arm and hemiplegia and hemiparesis (paralysis and weakness) following a cerebrovascular disease affecting the right dominant side.

A review of Resident #98's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/08/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognition. The MDS indicated the resident required partial/moderate assistance with personal hygiene. According to the MDS, showers/bathing had not been attempted during the assessment period due to the resident's medical condition or safety concerns.

A review of Resident #98's "Care Plan" problem area, dated 12/01/2023, revealed the resident was at risk for altered activities of daily living (ADL) function secondary to weakness, debility, and a history of cerebral vascular accident (CVA; stroke) with right-sided weakness/hemiparesis. The facility developed care plan interventions that directed staff to assist Resident #98 with

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F 677	Continued From page 13 completing ADL tasks each day. On 01/08/2024 at 1:39 PM, Resident #98 was observed with long fingernails on both hands. An observation on 01/09/2024 at 3:30 PM revealed Resident #98 had long, dirty nails on both hands. Observations on 01/10/2024 at 8:50 AM and on 01/10/2024 at 3:33 PM revealed Resident #98's fingernails were long. A review of Resident #98's "Shower Sheet/Skin Observation" forms, dated 01/06/2024, revealed staff documented the resident's nails were "clipped." However, during an observation of Resident #98's fingernails on 01/10/2024 at 3:51 PM, the Assistant Director of Nursing (ADON) stated it appeared Resident #98's nails were not trimmed on 01/06/2024. During an interview on 01/10/2024 at 7:15 AM with Registered Nurse (RN) #4, she stated the certified nursing assistants (CNA) were responsible for trimming the fingernails of residents who did not have a diagnosis of diabetes. According to RN #4, a podiatrist trimmed the fingernails for residents who had a diagnosis of diabetes. During an interview on 01/10/2024 at 7:28 AM, CNA #5 stated trimming fingernails was included in ADL care for residents without a diagnosis of diabetes. She said if a resident refused nail care, she documented the refusal on the resident's shower sheets. CNA #5 also stated a podiatrist trimmed the fingernails and toenails for residents who had a diabetes diagnosis.	F 677		

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F 677	Continued From page 14 During an interview on 01/10/2024 at 1:25 PM, CNA #6 stated that nail trimming/cleaning was provided during showers for residents who did not have a diagnosis of diabetes. CNA #6 stated he did not trim residents' nails if they were "too long." He stated if a resident refused to have their nails trimmed, the refusal was documented on the resident's shower sheets. During an interview on 01/10/2024 at 1:30 PM, CNA #7 stated she asked residents about trimming their fingernails during showers. CNA #7 stated Resident #98 did not normally refuse nail care. She stated she was unsure how long it had been since the resident's nails were trimmed, but stated they needed to be trimmed. During an interview on 01/11/2024 at 8:57 AM, the ADON she stated she expected staff to trim residents' fingernails on days the resident received a shower and as needed. She stated she expected nurses to monitor to ensure residents' fingernails were trimmed and to review the shower sheets to ensure they were accurate. She stated she expected residents' nails to be trimmed and cleaned. During an interview on 01/11/2024 at 9:24 AM, the Administrator stated she expected staff to keep residents' nails trimmed on a consistent basis.	F 677		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693	**It is the practice of this facility to provide care/services for highest well-being in accordance with State and Federal law.** **F693 - Tube Feeding Mgmt/Restore Eating Skills** **Address how the Deficiency will be resolved:**	

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F 693	Continued From page 15 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure 1 (Resident #91) of 10 residents receiving tube feeding received appropriate treatment and services to prevent complications. Specifically, observations revealed the tube feeding formula bottle for Resident #91 was not dated or timed when it was initiated to ensure the formula was not administered beyond 24 hours. Findings included: Review of a facility policy titled, "Enteral Medication Administration," dated March 2022, revealed, "Supplies should be dated when opened and must be replaced every 24 hours." Review of a facility policy titled, "Care and	F 693	1. Resident identified as: Resident #91. Tube feeding administration set was immediately changed and labeled with date and time the new set was initiated. 2. Education was immediately provided to licensed nurses to label all tube feeding formulas bags with date and time when initiated. Formula administration set is changed every 24 hours. 3. All residents with tube feeding orders are at high risk and have the potential to be affected by the alleged deficient practice. No other residents were identified as being negatively impacted. 4. An immediate sweep of resident rooms was conducted to verify all residents with tube feed formulas currently running had a date and time when administration set was initiated. 5. Include in the Matrix order to label with date and time when changing out the administration set every 24 hours. 6. Provide continued education for staff practices for handling, hang-time, changing tube feeding bags, and labeling with date and time are consistent with accepted standards of practice for infection control and manufacturer. 7. An environmental rounding tool was implemented, it includes checking the residents with tube	

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F 693	Continued From page 16 Treatment of Feeding Tubes," revised in June 2023, revealed, "9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. f. Ensuring that the product has not exceeded the expiration date." A review of Resident #91's "Resident Face Sheet" indicated the facility admitted Resident #91 on 04/12/2023 with diagnoses that included dysphagia (difficulty swallowing foods or liquids) and dysarthria (slurred speech) following a cerebral infarction (stroke). A review of Resident #91's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2023, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had difficulty swallowing or pain when swallowing. The MDS also revealed the resident utilized a feeding tube and received 51 percent or more calories and liquids through tube feeding. A review of Resident #91's "Care Plan" problem area, initiated 04/12/2023, revealed the resident required a feeding tube, which put the resident at risk for nutritional deficits and other medical complications. The facility developed interventions that directed staff to ensure the tube feeding supplies, formula, and tubing were changed as ordered. A review of Resident #91's physician "Orders" revealed an order started on 01/03/2024 for Jevity	F 693	feedings running to verify the bag has been labeled with date and time. 8. Audits will be daily Monday through Friday x2 weeks, Weekly x2, Bi-Weekly x2 and monthly x1. 9. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. **Adress who will be responsible for the correction of the Deficiency:** The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by February 16, 2024.	

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1.2 Cal (lactose-reduced tube feeding formula with fiber) to run at 60 milliliters per hour (ml/hr) via gastric tube and a water flush at 20 ml/hr, continuously, 24 hours per day. The order indicated the tube feeding may be disconnected for therapy as needed.

A review of Resident #91's "Medication Administration Record [MAR]," dated 01/01/2024 through 01/11/2024, revealed staff documented that Jevity tube feeding was administered as ordered.

On 01/08/2024 at 2:35 PM, an observation revealed Resident #91's Jevity tube feeding formula was infusing at 60 ml/hr. The observation revealed the tube feeding formula was not labeled with the date or time the formula was initiated.

On 01/10/2024 at 8:55 AM, an observation revealed Resident #91's Jevity tube feeding formula was infusing at 60 ml/hr and a bag of water was present. There was no label with the date or time the tube feeding formula was initiated.

During an interview on 01/10/2024 at 9:00 AM, Registered Nurse (RN) #8 indicated both the tube feeding formula and the water bag were changed every 24 hours. RN #8 noted that, once the formula and water bag were changed, it was documented in the resident's electronic health record (EHR). RN #8 indicated the date and time was also documented on the formula container and the water bag. RN #8 stated the documentation of the date and time was important because the formula was only good for 24 hours. RN #8 indicated she remembered she

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changed Resident #91's formula and water bag at approximately 6:30 AM because the infuser was beeping when she came in for her shift. However, RN #8 indicated she forgot to document the date or time on Resident #91's formula container or water bag.

During an interview on 01/11/2024 at 9:03 AM, RN #9 indicated the frequency to change a tube feeding was dependent on the physician's order. RN #9 indicated all residents were currently on a continuous feeding 24 hours per day. RN #9 stated once the feeding was changed, staff documented in the EHR and documented the date and time on the formula container and water bag. RN #9 indicated it was important to document the date and time because staff needed to know how long the feeding had been running because it was only good for 24 hours.

During an interview on 01/11/2024 at 9:47 AM, the Director of Nursing (DON) indicated the resident's name, the date and time the tube feeding formula started, and the flow rate should be documented on a tube feeding formula container.

During a follow up interview on 01/11/2024 at 10:16 AM, the DON indicated her expectation was for staff to follow physician orders for tube feedings. The DON stated there should be a label on the tube feeding container that indicated what type of formula was being used, the ordered rate, and the date and time it was started. She stated the information was important because the tube feeding was only good for 24 hours.

During an interview on 01/11/2024 at 10:25 AM, the Administrator indicated her expectation was

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F 693	Continued From page 19 for a tube feeding to be labeled when it was started, noting this was important because they did not want the feeding to infuse beyond its expiration. The Administrator indicated the time an infusion started could not be tracked if it was not labeled.	F 693	**It is the practice of this facility to provide care/services for highest well-being in accordance with State and Federal law.**	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to obtain a physician order for 1 (Resident #30) of 3 sampled residents receiving supplemental oxygen administration. Findings included: A review of a facility policy titled, "Oxygen Administration," last revised in June 2023, indicated, "1. Oxygen is administered under orders of a physician, except in the case of an emergency." The policy also revealed "4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders." A review of Resident #30's "Resident Face Sheet"	F 695	**F695 – Respiratory/Tracheostomy Care and Suctioning** **Address how the Deficiency will be resolved:** 1. Resident identified as: Resident #30 with COPD dependent on oxygen. The Provider was contacted immediately for order clarification to obtain written order to administer oxygen. 2. An immediate sweep of resident rooms was conducted to verify that all residents with oxygen stored in the room have a physician order to administer. 3. All residents currently on oxygen therapy are at risk for deficient practice. A 100% audit was performed by the Unit Manager and the Director of Nursing identifying residents currently on oxygen therapy per physician orders. No other residents were identified as being negatively impacted. 4. All Licensed Nursing staff were re-educated by the Director of Nursing/Designee to ensure all	

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F 695	Continued From page 20 revealed the facility admitted the resident on 11/16/2023 with diagnoses that included acute respiratory failure, chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen. A review of Resident #30's 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/22/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident utilized oxygen therapy while a resident at the facility. A review of Resident #30's "Care Plan" problem area, dated 11/16/2023, revealed the resident required respiratory support secondary to hypoxic episodes. The facility developed interventions that directed staff to provide oxygen as prescribed. A review of Resident #30's active physician "Orders," with orders dated 11/16/2023 through 01/09/2024, revealed no orders for oxygen administration. A review of Resident #30's "Treatment Administration History," dated 12/17/2023 through 01/11/2024, revealed that, despite no active physician order for supplemental oxygen, the resident had a treatment listed for staff to assess the resident's oxygen saturation level every shift and to titrate the oxygen flow rate between zero to five liters per minute (LPM) via nasal cannula to keep the resident's oxygen saturation above 90 percent. The oxygen treatment history revealed staff did not administer oxygen to the resident on 01/08/2024 or on 01/09/2024. The record had an "x" documented for the resident's oxygen saturation and oxygen flow rate for those dates.	F 695	residents who require oxygen therapy are provided the necessary services needed and a physician order is in place. 5. 48-hour chart checks after admission are in place with the DON/Designee to audit all required orders and verify they have been implemented. 6. Treatment orders will be monitored by DON/Designee and verification that physician orders are in place. 7. The DON or designee will monitor all new admissions with orders for Oxygen therapy if appropriate. 8. An environmental rounding tool was implemented, it includes checking the resident's rooms for Oxygen equipment. DON or designee will conduct this audit at random weekly time 4 weeks. Bi-monthly times 1 month. Monthly times 1 month. 9. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review. **Adress who will be responsible for the correction of the Deficiency:** The Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers will be responsible for the correction of this deficiency.	

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F 695	Continued From page 21 During observations of Resident #30 on 01/08/2024 at 11:20 PM, 01/09/2024 at 8:31 AM, and 01/09/2024 at 3:55 PM, the resident was observed wearing oxygen at 2 LPM. During an interview on 01/10/2024 at 7:28 AM, Certified Nursing Assistant (CNA) #5 stated Resident #30 had utilized supplemental oxygen since admission to the facility. During an interview on 01/10/2024 at 8:40 AM, Registered Nurse (RN) #1 stated a physician's order was required for supplemental oxygen. During an interview on 01/10/2024 at 8:00 AM, RN #4 stated Resident #30 had worn supplemental oxygen since admission to the facility. She stated all residents who received supplemental oxygen should have a physician's order. After reviewing the resident's electronic medical record, RN #4 confirmed Resident #30 did not have an order for supplemental oxygen administration. During an interview on 01/11/2024 at 8:56 AM, the Director of Nursing (DON) revealed a physician's order was required for supplemental oxygen. The DON stated that, upon admission from the hospital, Resident #30 requested oxygen. The DON stated the resident had been utilizing supplemental oxygen, but noted the facility did not have a physician's order to administer supplemental oxygen to the resident until 01/10/2024. During an interview on 01/11/2024 at 9:24 AM, the Administrator stated she expected staff to have a physician order before administering	F 695	**Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by February 16, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HUNTER HOLLOW	4090 WEST PIONEER PARKWAY WEST VALLEY CITY, UT 84120

(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
F 695	Continued From page 22 supplemental oxygen.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING 03 B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HUNTER HOLLOW	4090 WEST PIONEER PARKWAY WEST VALLEY CITY, UT 84120

(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 Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 01-16-2024 in the presence of the Administrator and the Facility Manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	E 000	Cole Julian Approved: 01-30-2024 POC: 03-18-2024	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or	E 004	**E004 – Develop EP Plan, Review and Update Annually** **Address how the Deficiency will be resolved:** 1. The Administrator and the Maintenance Director will utilize an interdisciplinary approach to develop, establish and maintain a comprehensive emergency preparedness program. 2. There will be red binders placed in key locations throughout the community. 3. In-service for employees on the Emergency Preparedness Plan will be completed. 4. Monthly for three months Administrator or designee will audit to assure emergency preparedness plans are in place throughout the community and bring these audits to QAPI monthly for three months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 01/26/24

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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	465075	A. BUILDING 03 B. WING	01/17/2024

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ROCKY MOUNTAIN CARE - HUNTER HOLLOW	4090 WEST PIONEER PARKWAY WEST VALLEY CITY, UT 84120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: E-0004 Based on observations made during the record review and interview made in the presence of the Administrator and facility manager on 01-16-2024 it was determined that the facility failed to develop and maintain a comprehensive emergency preparedness program that must be reviewed, and updated at least annually. This deficiency affected the required emergency preparedness testing program. Findings include: 1-During the record review it was discovered that the facility did not develop and maintain a comprehensive emergency preparedness program that must be reviewed, and updated at least annually in accordance with Title 42, Code	E 004	**Address who will be responsible for the correction of the Deficiency:** The Administrator, Maintenance Director and the Leadership Team will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 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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E 004	Continued From page 2 of Federal Regulations, 483.73.	E 004		
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 (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	E 039	**E039 – EP Testing Requirements** **Address how the Deficiency will be resolved:** 1. The building will hold an emergency preparedness tabletop exercise in the building. 2. The building will schedule to attend and/or hold a second emergency preparedness exercise by the end of 2024. 3. The Maintenance Director and the Leadership team will analyze the facility's response to the drill as well as maintain documentation of the drills, tabletops exercises, and emergency events, and revise the facility's emergency plan as needed. 4. The Maintenance Director will bring results to be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance.	

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E 039	Continued From page 3 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 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	E 039	**Address who will be responsible for the correction of the Deficiency:** The Administrator, Maintenance Director and the Leadership Team will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 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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E 039	Continued From page 4 (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 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	E 039		

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E 039	Continued From page 5 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: (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	E 039		

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E 039	Continued From page 6 [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: (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.	E 039		

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E 039	Continued From page 7 *[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 (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	E 039		

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E 039	Continued From page 8 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, 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	E 039		

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E 039	Continued From page 9 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 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	E 039		

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E 039	Continued From page 10 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 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: E-0039 Based on record review and interview made in the presence of the Administrator and facility manager on 01-16-2024 it was determined that the facility failed to conduct exercises to test the emergency plan at least annually. This deficiency affected the annual and table top required emergency preparedness drill exercises	E 039		

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E 039	Continued From page 11 program. Findings include: 1-During the record review it was discovered that the facility did not have any record that they had completed a full-scale community-based exercise the required testing standard for testing the emergency plan. 2- During the record review it was discovered that the facility did not have any record that they had completed a second full scale or a table top exercise to meet the requirements of the emergency plan. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes 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 emergency plan.	E 039		

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E 039	Continued From page 12 (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.	E 039		
K 000	INITIAL COMMENTS K-000 Initial Comments. Statutory and regulatory authority for this Life Safety Code survey that was conducted on 01-16-2024 in the presence of the Administrator and the Facility Manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) Life Safety from fire.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	K 223	**K223 – Doors with Self-Closing Devices** **Address how the Deficiency will be resolved:** 1. The Maintenance Director repaired the fire door that was not closing on January 22, 2024. 2. An initial audit on fire doors for proper closure will be completed by the Maintenance Director and/or Designee. 3. The Maintenance Director/Designee will conduct a monthly audit on fire doors in the community to ensure they close.	

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K 223	Continued From page 13 This REQUIREMENT is not met as evidenced by: K-223 Based upon observations made in the presence of the facility manager on 01-16-2024, it was determined that the facility did not maintain the Fire/smoke control doors so that they shut to resist the passage of Fire/smoke in accordance with NFPA101 19.2.2.2.6. This deficiency affected 1 of several rated doors Findings include: 1-During the testing of the fire/smoke doors it was discovered that the fire rated door to the dining room from the 100 corridors did not close to the latching position as required.	K 223	4. The audit will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024.	
K 291 SS=D	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: K-291 Based upon observations made during the record review made in the presence of the facility manager on 01-16-2024 it was determined that the facility did not provide an emergency lighting system in accordance with NFPA 101 20.2.9.1. This deficiency affected one of the monthly required tests. Findings include: 1-During the record review the facility failed to provide documentation for the November monthly testing of the emergency lighting system.	K 291	**K291 – Emergency Lighting** **Address how the Deficiency will be resolved:** 1. The emergency lighting has been checked monthly since December 2023 and is up to date. 2. An initial audit on emergency lighting will be completed by the Maintenance Director and/or Designee to ensure that all emergency lighting is operating correctly. 3. Monthly emergency lighting tests will be run by the Maintenance Director on the first Sunday of	

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K 291	Continued From page 14 Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds in accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).	K 291	every month going forward. 4. Monthly for three months the Administrator will audit to ensure that the emergency lighting test has been completed. 5. The audit will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 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 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced	K 321	**K321 – Hazardous Areas - Enclosures** **Address how the Deficiency will be resolved:** 1. Maintenance Director removed the bungie cord from the dietary storage room door on January 18, 2024. 2. The Maintenance Director educated the Dietary Manager about the importance of keeping the door closed on January 18, 2024.	

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K 321	Continued From page 15 by: K-321 Based upon observations made in the presence of the facility manager on 01-16-2024, it was determined that the facility did not maintain hazardous areas to be fire and smoke separated from other sections of the facility in accordance with NFPA 101 19.3.2.1. This deficiency affected one of the smoke compartments Findings include: During the facility tour it was observed that the door to the dietary storage room was being held open with a bungie cord and by passing the required door closure. The door is required to be self-closing or automatic closing to the latch position in accordance with NFPA 101 19.3.2.1.	K 321	3. The Dietary Manager will educate dietary staff on the importance of keeping the door closed. 4. The Maintenance Director and/or Designee will conduct a weekly audit to ensure that the door is closed. 5. The audit will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator, Maintenance Director and Dietary Manger or will be responsible for the correction of this deficiency.	
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: K-355 Based upon observations made in the presence of the facility manager on 01-16-2024, it was determined that the facility did not maintain portable fire extinguishers in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1 This deficiency affected 1 of the required tests. Findings include:	K 355	**Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024. **K365 – Portable Fire Extinguishers** **Address how the Deficiency will be resolved:** 1. The heft tests on the portable fire extinguishers have been completed monthly since December 2023 and are up to date. 2. An initial audit on all fire extinguishers for heft tests will be	

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K 355	Continued From page 16 1-During the facility tour it was discovered that the facility did not complete the required heft tests on the portable fire extinguishers during the month of November in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5.	K 355	completed by the Maintenance Director and/or Designee. 3. Monthly heft tests on the portable fire extinguishers will be completed by the Maintenance Director on the first Sunday of every month.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: K-0712 Based upon observations made during the record review in the presence of the facility manager on 01-16-2024, it was determined that the facility did not conduct fire drills held at unexpected times under varying conditions at least quarterly on each shift in accordance with NFPA 101 19.7.1.2. This deficiency affected all required fire drills. Findings include: 1- During the record review the facility failed to provide documentation of the required 12 fire drills and or a documented orientation training program. The missing drill was the 1st quarter NOC shift, 2nd quarter the NOC shift, 3rd quarter	K 712	4. Monthly for three months the Administrator will audit to ensure that the heft tests on the portable fire extinguishers have been completed. 5. The audit will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024. **K712 – Fire Drills** **Address how the Deficiency will be resolved:** 1. The Maintenance Director and/or Designee will conduct unexpected	

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K 712	Continued From page 17 day shift and the 4th quarter afternoon shift and the NOC shift. Drills shall be held at unexpected time under varying conditions at least quarterly on each shift in accordance with NFPA 101 19.7.1.4. Through 19.7.1.7. These findings were confirmed with the facility manager.	K 712	fire drills at AM, PM. And NOC shift for each quarter. 2. Fire Drills will be recorded using the Maintenance Prevention Program TELS for each fire drill conducted. 3. In-service for employees on Fire Drills will occur. 4. The administrator and/or Designee will complete a monthly audit for three months to ensure that a fire drill has been conducted and on what shift the fire drill was completed. 5. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator, Maintenance Director and Human Resources will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024. **K781 – Portable Space Heaters** **Address how the Deficiency will be resolved:**	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: K-781 Based upon observations made in the presence of the plant manager on 01-16-2024, it was determined that the facility was using portable space heaters in. NFPA 101 19.7.8. This deficiency affected two smoke compartments. Findings include: 1-During the facility tour a portable space heater was discovered in the medical records office. Portable space-heating devices shall be prohibited in all health care occupancies in accordance with NFPA 101 19.7.8. 2- During the facility tour a portable space heater was discovered at the nurse's station at the west end of the 200 corridors. Portable space-heating devices shall be prohibited in all health care occupancies in accordance with NFPA 101 19.7.8.	K 781		

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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 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: K-918: During the record review made in the	K 918	1. The portable space heater in Medical Records and 200 Hall Nurses stations were immediately removed on January 17, 2024. 2. An audit was conducted to check all offices and nurse stations to ensure that no portable space units are being used. 3. Staff will be educated on the dangers of using portable space heaters in the community. 4. The Maintenance Director and/or Designee will complete weekly audit for 12 weeks of offices and nurse stations to ensure that there are no portable space heaters in use. 5. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024.	

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K 918	Continued From page 19 presence of the facility manager on 01-16-2024, it was determined that the facility did not maintain, inspect and exercise the facilities emergency generator set in accordance with NFPA 99 6.4.4 and NFPA 110 8.4.2.3. This deficiency affected the required tests for the emergency generator. Findings include: 1-During the record review it was discovered that the facility did not have any records to indicate that all of the weekly testing of the generator had been completed. 2- During the record review it was discovered that the facility did not have any records to indicate that the monthly load test for the month of November had been completed. The facility manager was present when these deficiencies were discovered. 3- During the record review the facility failed to provide documentation that the Maintenance of the generator batteries had been conducted. Maintenance of Lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted in accordance with NFPA 110 8.3, 8.3.7 4- During the record review it was discovered the facility did not complete the annual load Bank test of the emergency generator. In accordance with NFPA 99 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111, 700.10 (NFPA 70). The last test was completed on 06-23-2021.	K 918	**K918 – Electric Systems – Essential Electric System Maintenance and Testing** **Address how the Deficiency will be resolved:** 1. Weekly testing on the generator was immediately completed on 01/18/2024 by the Maintenance Director. Going forward the weekly testing on the generator will occur weekly every Thursday. 2. The Administrator or designee will complete a bimonthly audit for three months to ensure that the weekly testing is occurring. 3. The monthly load test on the generator have been completed monthly since December 2023 and are up to date. The Maintenance Director or designee will ensure that the monthly load test occurs every month and document the test. 4. The Administrator or designee will complete a monthly audit for three months to ensure that the monthly test is completed. 5. The batteries in the generator were replaced. Going forward the monthly test of the batteries will be completed during the weekly testing of the generator. 6. The Administrator or designee will	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		

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K 920	Continued From page 20 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: K-920 Based upon observations made in the presence of the facility manager on 01-16-2024, it was determined that the facility did not use plug stripes and or extension cords in accordance with NFPA 101, 99 and 70. This deficiency affected 2 of several smoke compartments. Findings include: 1-During the facility tour it was observed that a power strip was plugged into another power strip in the Activities room office. Listed or labeled	K 920	complete a bimonthly audit for three months to ensure that the weekly testing is occurring. 7. The annual load Bank test will be completed. 8. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024. **K920 – Electrical Equipment – Power Cords and Extension Cords** **Address how the Deficiency will be resolved:** 1. The power strip plugged into another power strip in the Activities Office was immediately removed on January 16, 2024. 2. The Mini Fridge that was plugged into an extension cord in the ADON office was immediately removed on January 16, 2024.	

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K 920	Continued From page 21 equipment shall be installed and used in accordance with any instructions included in the listing or labeling in accordance with NFPA 70 110-3b 2- During the facility tour it was observed that a residential grade extension cord was in use in the ADON office for the power to the mini fridge. Flexible cords and cables shall not be used as a substitute for the fixed wiring of a structure NFPA 70 400.7.	K 920	3. An audit will be completed on by the Maintenance Director and/or Designee of all offices to ensure that power cords are used properly and that there are no extension cords are in use. 4. Maintenance Director will ensure that the mini fridge is plugged into an appropriate outlet.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel	K 921	5. The Maintenance Director and/or Designee will conduct bi-weekly audits for three months of all offices to ensure that power strips are being used properly and that there are no extension cords in use and that mini fridge are plugged into the appropriate outlets. 6. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING 03 B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HUNTER HOLLOW	4090 WEST PIONEER PARKWAY WEST VALLEY CITY, UT 84120

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K 921	Continued From page 22 responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: K-921 Based on records review, observation, and an interview with the facility manager on 01-16-2024 the facility failed to maintain documentation of the inspections for the Patient-Care Related Electrical equipment (PCREE). This deficiency affected all residents. Findings include: During the record review there was no documentation of the inspections of the Patient Care Related Electrical Equipment in use throughout the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facility Code 2012. 3.3.137. NFPA 99 10.3 through 10.5.8. An interview on 11-27-2023 with the facility Manager confirmed these findings.	K 921	**K921 – Electrical Equipment – Testing and Maintenance Requirements** **Address how the Deficiency will be resolved:** 1. The Maintenance Director will create a log that contains all Patient-Care Related equipment. 2. The Maintenance Director will use this log to keep a record of electrical equipment tests, repairs, and modifications. 3. The Administrator or designee will conduct random monthly audits for three months to ensure that that the Patient-Care Related equipment log is being used. 4. The audits and Patient-Care Related Log will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months to ensure compliance. **Address who will be responsible for the correction of the Deficiency:** The Administrator and the Maintenance Director will be responsible for the correction of this deficiency. **Address the proposed timeframe for the completion of the correction:** This Deficiency will be corrected by March 18, 2024.	