STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	4305 S Poplar , Casper, Wyoming, 82601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/28/2025 and 08/29/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) construction with plan approval in 1967 and 1973. The building was equipped with a supervised wet sprinkler system with an anti-freeze branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 82 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		10/01/2025
K0100 SS = D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain ceiling construction in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The ceiling assembly is designed to trap hot air and gases around fire sprinklers allowing the sprinklers to operate at a specified temperature. Failure to maintain the ceiling could allow hot air and gases to escape above the ceiling limiting the effectiveness of the fire sprinkler system. The deficiency affected (1) of multiple rooms. The deficiency could affect all residents and staff who utilize the affected room. The findings were:	K0100	Corrective Action Taken: On 08/28/2025, immediately upon identification of the deficiency, the 12'x12' opening in the ceiling of the bathroom in room 608 was repaired by the facility maintenance team. The repair included installation of fire-rated gypsum board matching the existing ceiling construction, proper taping, and finishing to maintain the required fire-resistance rating. The repair was verified by the Maintenance Director to ensure compliance with NFPA 101 Life Safety Code requirements and NFPA 13 standards for sprinkler system effectiveness. Identification of Other Areas with Potential to be Affected: On 08/28/2025, the Maintenance Director conducted a facility-wide inspection of all resident room bathrooms and common areas to identify any similar ceiling breaches or construction deficiencies that could affect sprinkler system effectiveness. The inspection included visual examination of all ceiling surfaces and documentation of findings using the facility's Life Safety inspection checklist. Systemic Changes and Measures Implemented: The facility's maintenance policy was revised on 08/29/2025 to include specific protocols for ceiling	10/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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K0100 SS = D	Continued from page 1 Observations on 08/28/2025 at 1:25 PM revealed the facility failed to maintain the ceiling construction in the bathroom inside room 606. Observations revealed a roughly 12"x12" opening had been cut into the gypsum ceiling, allowing hot air and gases to escape the room limiting the effectiveness of the ceiling mounted fire sprinkler. Interview the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.1.1.1.3, 4.6.12.1, 9.7.1, and 2010 NFPA 13, Section 8.5.4.1.1	K0100	Continued from page 1 repairs and modifications, requiring: Pre-approval from the Maintenance Director for any ceiling alterations Documentation of all ceiling work in the maintenance log Monthly ceiling integrity inspections Maintenance training was conducted by 10/10/2025 for all maintenance personnel on: NFPA requirements for ceiling construction Proper procedures for ceiling repairs Impact of ceiling breaches on sprinkler system effectiveness A new preventive maintenance schedule was implemented by 10/15/2025 to include regular inspection of ceiling integrity throughout the facility. Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all ceiling surfaces for the first month, then monthly thereafter, using a comprehensive ceiling integrity checklist. The Director of Nursing will perform independent monthly audits to verify compliance. Results will be documented in the facility's maintenance tracking system and reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance with the set-forth protocols is achieved and maintained for three consecutive quarters. Date of Compliance: 10/15/2025	
K0223 SS = E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices	K0223	K-223: Doors with Self-Closing Devices Corrective Action Taken: On 08/28/2025, the Maintenance Director immediately inspected and repaired all identified self-closing doors. Specifically, the	10/10/2025

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K0223 SS = E	Continued from page 2 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 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure doors in a hazardous room are kept in the closed position in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure doors in a hazardous room are self-closing and remain in the closed position could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected two (2) of multiple doors. The findings were: Observations on 08/28/2025 at 1:19 PM revealed main storage room in Hall 5 was protected with a self-closing door due to the room being greater than 50 SF in size and the storage of flammable or combustible materials. Further observation revealed the self-closing door failed to close and latch, keeping the door in the closed position. Observations on 08/28/2025 at 2:30 PM revealed the boiler room in Hall 6 was protected with a self-closing door due to the boiler room being identified as a hazardous area. Further observation revealed the self-closing door failed to close and latch, keeping the door in the closed position. Observations on 08/28/2025 at 3:25 PM revealed the main linen storage room was protected with a self-closing door due to the room being greater than 50 SF in size and the storage of flammable or combustible materials. Further observation revealed the self-closing door failed to close and latch, keeping the door in the closed position.	K0223	Continued from page 2 following corrections were made: Hall 5 main storage room door: Adjusted door closer mechanism and replaced worn hinges Hall 6 boiler room door: Replaced door closer and adjusted closing tension Main linen storage room door: Repaired self-closing mechanism and adjusted door alignment Utility room door: Installed missing latch plate and adjusted door closer mechanism All doors were tested and verified to properly close and latch automatically after repairs were completed. Identification of Other Areas with Potential to be Affected: On 09/29/2025, the Maintenance Director conducted a facility-wide inspection of all self-closing doors in hazardous areas, including storage rooms over 50 SF, mechanical rooms, and utility spaces. This inspection included testing of closing mechanisms, latching hardware, and door alignment. A comprehensive inventory of all self-closing doors was created and added to the preventive maintenance system. Systemic Changes and Measures Implemented: Implemented new preventive maintenance schedule for quarterly inspection and testing of all self-closing doors, effective 09/01/2025 Created detailed inspection checklist for door closing mechanisms, latching hardware, and alignment Updated facility maintenance policy to include specific requirements for self-closing door maintenance and testing Conduct in-service training for maintenance staff on proper door adjustment and repair procedures on 10/10/2025	

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K0223 SS = E	Continued from page 3 Observations on 08/28/2025 at 3:37 PM revealed the utility room was protected with a self-closing door due to the room being greater than 50 SF in size and the storage of flammable or combustible materials. Further observation revealed the door assembly was missing a latch plate and the self-closing door failed to latch, keeping the door in the closed position. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7.1	K0223	Continued from page 3 Established protocol requiring immediate reporting of any malfunctioning self-closing doors by all facility staff Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all self-closing doors for proper operation for four weeks, then monthly thereafter. Results will be documented on standardized inspection forms. The Safety Committee will review inspection results monthly. The Director of Engineering will conduct quarterly audits of door maintenance records and physical inspections to ensure continued compliance. The Maintenance Director will report monitoring results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance with the set-forth protocols is achieved. Date of Compliance: 10/10/2025	
K0271 SS = D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide an exit discharge that provides a level walking surface meeting the provisions of 2012 NFPA 101, Life Safety Code with respect to abrupt changes in walking surfaces in the means of egress. Failure to provide a level walking surface at the means of egress could delay or impede egress in an emergency leading to injury or death. The deficiency affected one (1) of multiple exits. The deficiency could affect all residents, staff, and volunteers within Hall 5. The	K0271	K-271: Discharge from Exits Corrective Action Taken: On 08/28/2025, immediately following the observation, the facility maintenance team assessed the concrete walking surface at the north exit of Hall 5. On 09/29/2025, a licensed contractor was engaged to repair the elevation change in the concrete walking surface. The contractor will replace the raised portion of the concrete to ensure the change in elevation does not exceed one-quarter inch (1/4"), in compliance with 2012 NFPA 101, Life Safety Code requirements. The repair will be completed and verified by the Maintenance Director on 10/24/2025. Identification of Other Areas with Potential to be Affected: On 09/19/2025, the Maintenance Director and Safety Officer conducted a comprehensive inspection of all facility exit discharges and walking surfaces in the means of egress throughout the facility. This inspection included measurement of all changes in elevation using calibrated measurement tools. Documentation of this assessment is maintained in the facility's maintenance records.	10/24/2025

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K0271 SS = D	Continued from page 4 findings were: Observation on 08/28/2025 at 1:25 PM revealed the north exit from Hall 5 included a concrete walking surface with an abrupt change in elevation of walking surface. 2012 NFPA 101, Life Safety Code, specifies that abrupt changes in elevation of walking surfaces shall not exceed one-quarter inch (1/4”). Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 19.2.7, 7.7, 7.1.6	K0271	Continued from page 4 Systemic Changes and Measures Implemented: The facility's preventive maintenance program has been enhanced to include monthly inspections of all exit discharge walking surfaces, with specific attention to changes in elevation. The Maintenance Director will provide in-service training to all maintenance staff on 10/02/2025 regarding NFPA 101 requirements for exit discharge walking surfaces and proper inspection procedures. The facility's Safety Committee revised the "Environmental Rounds Policy" on 09/30/2025 to include specific evaluation criteria for exit discharge walking surfaces. Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all exit discharge walking surfaces for the first month, then monthly thereafter, using the new Exit Discharge Inspection Checklist. The Safety Officer will conduct independent quarterly audits of all exit discharges to ensure continued compliance. Results of these inspections and audits will be documented and reported to the Quality Assurance and Performance Improvement (QAPI) committee quarterly. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 10/24/2025	
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test battery-operated emergency lighting equipment and exit signs in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test	K0291	K-291: Emergency Lighting Corrective Action Taken: On 08/29/2025, the Maintenance Director immediately initiated a facility-wide inspection of all battery-operated emergency lighting equipment and exit signs. All units were tested for proper function and battery capacity. A comprehensive emergency lighting testing program was implemented on 09/01/2025, which includes both monthly 30-second functional tests and annual 90-minute duration tests in accordance with NFPA 101 requirements. The Maintenance Director established a documented testing schedule and standardized testing logs for tracking compliance. Identification of Other Areas with Potential to be	10/10/2025

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K0291 SS = F	Continued from page 5 battery-operated emergency lighting equipment as required could result in inadequate lighting or failure to identify exit access during an emergency, resulting in injury or death. The deficiency impacted all battery powered exit signage and emergency lighting throughout the facility. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility failed to demonstrate the following testing of the battery-operated emergency lighting equipment and exit signs in accordance with 2012 NFPA 101, Life Safety Code: a) Annual functional testing for a minimum of 1-1/2 hours - 7.9.3.1.1 b) Monthly functional testing for not less than 30 seconds – 7.9.3.1.1 Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiencies. REF: 2012 NFPA 101, Sections 19.2.9, 19.2.10, 7.9.3.1, 7.10.9.2	K0291	Continued from page 5 Affected: The Maintenance Director conducted a complete inventory of all battery-operated emergency lighting units and exit signs throughout the facility on 09/02/2025. This inventory has been documented and mapped to ensure all emergency lighting equipment is included in the testing program. All areas of the facility were assessed, including corridors, stairwells, nursing stations, and service areas. Systemic Changes and Measures Implemented: Facility walk-thorough identifying areas of additional signage. Monthly walk through with the addition of new signage for lighted signage. Updated monthly testing schedule: Emergency lighting tests conducted on the first Tuesday of each month for all signs. Annual 90-minute duration tests scheduled for January of each year to cover all signs, new/old. Maintenance staff will receive comprehensive training on 10/3/2025 regarding illuminated signage for the facility and to identify areas of need. Implemented backup notification system to ensure testing compliance for new and old signage. Monitoring and Quality Assurance: The Director of Maintenance will conduct monthly audits of emergency lighting testing logs to ensure compliance with testing requirements. The Facility Safety Officer will perform quarterly reviews of all emergency lighting documentation and testing procedures. Results will be reported monthly to the Safety Committee and quarterly to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 10/10/2025	
K0293 SS = D	Exit Signage CFR(s): NFPA 101	K0293	K-293: Exit Signage	10/08/2025

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K0293 SS = D	Continued from page 6 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide readily visible signs to mark exit access in all cases where the exit or way to reach the exit is not readily apparent to the occupants in accordance with section 7.10 of the 2012 NFPA 101, Life Safety Code. Failure to provide exit and directional signage in accordance with the 2012 NFPA 101 could impede egress leading to injury or death in the case of an emergency. The deficiencies affected (2) of multiple exit access corridors. The deficiencies could affect all residents, staff, and visitors using the facility. The findings were: Observation on 08/28/2025 at 1:25 PM revealed the facility failed to provide readily visible exit signs to mark exit access at the intersections of Hall 3 and Hall 5, and at the doors separating Hall 5 and the Dining Room, in accordance with section 7.10 of the 2012 NFPA 101, Life Safety Code. Observation on 08/28/2025 at 2:05 PM revealed the facility failed to provide readily visible exit signs to mark exit access at the intersections of Hall 2 and Hall 6, and the doors separating Hall 6 and the Dining Room, in accordance with section 7.10 of the 2012 NFPA 101, Life Safety Code. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the time of the observation acknowledged the deficiencies. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiencies. REF: 2012 NFPA 101, Sections 19.2.10, 7.10	K0293	Continued from page 6 Corrective Action Taken: On 08/28/2025, immediately following the survey, the Maintenance Director conducted a thorough assessment of all exit and directional signage throughout the facility. By 09/12/2025, the facility contacted contractors to install illuminated exit signs at the intersections of Hall 3 and Hall 5, the doors separating Hall 5 and the Dining Room, the intersections of Hall 2 and Hall 6, and the doors separating Hall 6 and the Dining Room. All newly installed exit signs are connected to the emergency lighting system to ensure continuous illumination in accordance with NFPA 101, Section 7.10. The Maintenance Director verified proper installation and illumination of all new exit signs on 09/29/2025. Identification of Other Areas with Potential to be Affected: On 08/29/2025, the Maintenance Director and Safety Committee conducted a facility-wide inspection of all corridors, intersections, and egress paths to identify any additional areas requiring exit or directional signage. This comprehensive assessment included verification of proper illumination and emergency power connection for all existing exit signs. Documentation of this assessment is maintained in the facility's fire safety records. Systemic Changes and Measures Implemented: The facility has implemented the following systemic changes: Updated the preventive maintenance program to include monthly inspections of all exit and directional signage, effective 10/01/2025 Revised the Facility Safety Policy to include specific requirements for exit signage placement and illumination in accordance with NFPA 101, Section 7.10 Conducted in-service training for maintenance staff on exit signage requirements and inspection procedures on 10/08/2025 Created a comprehensive exit signage map indicating all required locations for exit and directional signs throughout the facility Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all exit	

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K0293 SS = D		K0293	Continued from page 7 and directional signage for the first month, then monthly thereafter. The Safety Officer will perform independent quarterly audits of exit signage compliance. Results will be documented using the Exit Signage Compliance Checklist. The Safety Committee will review findings monthly and report to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance:10/08/2025	
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance and testing for the kitchen range hood and kitchen extinguishing systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to provide maintenance and testing of kitchen range hoods and	K0324	K-324: Cooking Facilities Corrective Action Taken: On 08/29/2025, the Maintenance Director immediately scheduled a complete inspection and testing of the kitchen range hood and fire suppression system with our contracted fire protection vendor. The inspection and testing were completed by 10/10/2025. The facility has implemented a new maintenance tracking system that automatically schedules required semi-annual inspections and testing of the kitchen hood system. The Maintenance Director has established a contract with our fire protection vendor to conduct these inspections every January and July. Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide review of all fire protection systems and equipment on 08/31/2025 to identify any other systems requiring regular inspection and testing schedules. This review included verification of maintenance records for all kitchen equipment and fire suppression systems throughout the facility. Systemic Changes and Measures Implemented: Created a comprehensive preventive maintenance schedule for all kitchen fire protection systems using digital tracking software by 10/10/2025 Developed and implemented a new policy titled "Kitchen Fire Protection Systems Maintenance and Testing" by 10/10/2025	10/10/2025

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K0324 SS = D	Continued from page 8 kitchen extinguishing systems could result in injury or death in the event of a fire in the kitchen. The deficiency affected one (1) commercial range hood and extinguishing system. The deficiency could affect all staff working in the kitchen. The findings were: Documentation review on 08/29/2025 beginning at 9:35 AM revealed the facility failed to provide evidence of testing and maintenance of listed hoods every 6 months in accordance with the 2011 NFPA 96, Section 11.5. Documentation indicated the facility tested the listed hood in July of 2025, but could not provide additional evidence that testing and maintenance had occurred every six months. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of observation acknowledged the deficiencies. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.3.2.5.1, 9.2.3, and 2011 NFPA 96 Section, 11.5	K0324	Continued from page 8 Established automatic calendar reminders for scheduling semi-annual inspections Created a documentation system to maintain inspection and testing records Implemented a monthly audit process to verify compliance with maintenance schedules Conducted in-service training for maintenance staff on 10/03/2025 regarding new procedures and documentation requirements Monitoring and Quality Assurance: The Director of Environmental Services will conduct monthly audits of the maintenance tracking system to ensure compliance with the semi-annual inspection schedule. The Maintenance Director will maintain a log of all inspections, testing, and maintenance activities related to the kitchen hood system. Results will be reported monthly to the Safety Committee and quarterly to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 10/10/2025	
K0331 SS = D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This STANDARD is NOT MET as evidenced by:	K0331	K-331: Interior Wall and Ceiling Finish Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted an immediate assessment of the wall covering in the main lobby. By 10/01/2025, the facility will contract with Western Fire Protection Services to test and document the flame spread rating of the existing wall covering. Wall coverings will be certified or removed by 10/10/2025 Identification of Other Areas with Potential to be Affected: By 10/08/2025, the Maintenance Director and Safety Committee conducted a facility-wide inspection of all interior wall and ceiling finishes to identify any other areas with potentially non-compliant materials. The inspection will include all resident rooms, corridors, common areas, and service areas. Documentation of flame spread ratings was verified for all existing wall and ceiling finishes throughout the	10/08/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	4305 S Poplar , Casper, Wyoming, 82601

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K0331 SS = D	Continued from page 9 Based on observation, document review, and staff interview, the facility failed to provide documentation that the wall covering in the main lobby meets the flame spread requirements as specified within the 2012 NFPA 101, Life Safety Code. Failure to provide interior wall finishes with the specified flame spread classification could contribute to flame spread in the event of a fire, leading to injury or death. The deficiency affected the main lobby. The deficiency could affect all residents, staff, and visitors using the main lobby. The findings were: Document review on 08/29/2025 beginning at 9:35 AM revealed the facility failed to provide documentation ensuring the interior wall finishes in the main lobby meet the flame spread and performance criteria as specified in the 2012 NFPA 101, sections 19.3.3.2 and 10.2. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections, 19.3.3.2, 10.2, 10.2.8.1	K0331	Continued from page 9 facility. Systemic Changes and Measures Implemented: The facility has implemented the following systemic changes: Created new policy "Interior Finish Requirements and Documentation" effective 10/08/2025 Developed interior finish specification checklist for all future renovations and repairs Updated procurement policy to require verification of flame spread ratings prior to purchase of any interior finish materials Established quarterly documentation review process for all interior finish materials Conducted in-service training on 10/08/2025 for maintenance staff regarding NFPA 101 requirements for interior finishes Monitoring and Quality Assurance: The Maintenance Director will conduct monthly inspections of all interior finishes using the newly developed checklist. The Safety Officer will perform quarterly audits of interior finish documentation and maintenance records. Results will be tracked through the facility's maintenance management system. The Safety Committee will review findings monthly and report to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 10/08/2025	
K0345 SS = E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and	K0345	Corrective Action Taken: On 08/29/2025, the Maintenance Director immediately implemented a comprehensive fire alarm system testing and documentation protocol in accordance with NFPA 72 requirements. The facility contracted an outside company to conduct all outstanding required tests, including monthly activation of supervising station alarm systems, semi-annual lead-acid battery inspections, semi-annual battery load voltage tests, and semi-annual water flow	10/08/2025

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K0345 SS = E	Continued from page 10 NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of maintenance and testing of the fire alarm system in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The deficiency could affect all residents, staff, and volunteers. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility tested the fire alarm system on April 18th, and July 14th, 2025, but failed to provide documentation of the following tests in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code: a) Monthly activation of supervising station alarm systems - Table 14.4.5(24) b) Semi-annual inspection of lead-acid batteries - Table 14.3.1(3)(d) c) Semi-annual battery load voltage test Table - 14.4.5 (6)(3) d) Semi-annual inspection of water flow alarm devices – Table 14.4.5 (15)(m) Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.7.6, 4.6.12, 9.6.1.5 and 2010 NFPA 72, Sections 14.4.5	K0345	Continued from page 10 alarm device inspections. These tests were completed on 08/30/2025. All test results were documented and filed in the facility's fire safety compliance binder. Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide audit of all fire safety systems and documentation on 08/31/2025 to identify any other gaps in testing or maintenance records. This audit included review of all fire alarm components, sprinkler systems, and associated documentation requirements per NFPA 70 and NFPA 72 standards. Systemic Changes and Measures Implemented: Implemented new electronic maintenance management system on 10/01/2025 that automatically schedules and tracks all required fire alarm system testing per NFPA 72 requirements. Created detailed testing schedule with the following requirements: Monthly activation of supervising station alarm systems Semi-annual lead-acid battery inspections (January and July) Semi-annual battery load voltage tests (January and July) Semi-annual water flow alarm device inspections (January and July) Updated facility policy "Fire Alarm Testing and Maintenance" on 09/02/2025 to include specific testing requirements and documentation procedures. Provided comprehensive training to maintenance staff on 10/08/2025 regarding updated testing requirements and documentation procedures. Monitoring and Quality Assurance: The Director of Engineering will conduct monthly audits of fire alarm testing documentation to ensure compliance with all	

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K0345 SS = E		K0345	Continued from page 11 NFPA requirements. The Safety Committee will review testing documentation monthly and report findings to the QAPI committee quarterly. The Maintenance Director will maintain a testing compliance dashboard that will be reviewed weekly by facility administration. Any identified deficiencies will be immediately addressed and corrective actions implemented. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 10/08/2025	
K0351 SS = D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on site observations and staff interview, the facility failed ensure proper installation of the fire sprinkler systems in accordance with 2010 NFPA13, Standard for the Installation of Sprinkler Systems. Failure to ensure proper installation of the fire sprinkler systems could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system. The deficiency could affect all residents, staff, and volunteers at the facility. The citations were:	K0351	K-351: Sprinkler System - Installation Corrective Action Taken: On 08/28/2025, immediately upon identification of the deficiencies, the Maintenance Director removed all items stored within 18 inches of sprinkler heads in the medication room and throughout the facility. The Maintenance Director also properly installed the fire sprinkler escutcheons in room 106 to ensure they were tight against the ceiling, eliminating any exposed annular space. A facility-wide inspection was conducted to verify proper clearance around all sprinkler heads and proper installation of all escutcheons. Identification of Other Areas with Potential to be Affected: On 09/29/2025, the Maintenance Director and Safety Officer conducted a comprehensive facility-wide assessment of all sprinkler systems, including all resident rooms, storage areas, medication rooms, and common areas. This inspection documented the location of each sprinkler head and verified proper clearance and installation requirements per NFPA 13 standards. Systemic Changes and Measures Implemented: The facility's Storage and Fire Safety Policy was revised on 08/30/2025 to include specific requirements for maintaining 18-inch clearance below sprinkler heads and proper installation of sprinkler components. New visual markers were installed at the 18-inch clearance level in storage areas to clearly indicate required clearance zones. Staff education was conducted by 10/10/2025 regarding proper storage requirements and sprinkler clearance	10/10/2025

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K0351 SS = D	Continued from page 12 Observations on 08/28/2025 starting at 12:15 PM revealed the facility failed to provide adequate clearance between the fire sprinkler system and the storage in the medication room. The storage was within eighteen inches (18") of the ceiling-mounted fire sprinkler deflectors creating an obstruction to sprinkler discharge pattern development. Further observations revealed multiple locations throughout the facility with storage within eighteen inches of the ceiling-mounted fire sprinkler deflectors, creating obstructions to sprinkler discharge pattern development. Observation on 08/28/2025 at 4:00 PM revealed the fire sprinkler escutcheons for two (2) ceiling-mounted fire sprinklers in room 106 were not installed tight to the ceiling, exposing the annular space around the sprinklers. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, and 2010 NFPA 13 Section 6.2.7, 8.5.6	K0351	Continued from page 12 requirements. This training has been incorporated into new employee orientation and annual competency requirements. Monthly preventive maintenance checks were implemented to inspect all sprinkler heads and escutcheons for proper installation and clearance. Monitoring and Quality Assurance: The Maintenance Director will conduct weekly rounds to ensure compliance with sprinkler clearance requirements and proper installation of all sprinkler components. The Safety Officer will conduct independent monthly audits of sprinkler system compliance using a standardized audit tool. Results of these inspections will be documented and reviewed during monthly Safety Committee meetings. The Safety Committee will report findings to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 10/10/2025	
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K0353	Plan of Correction Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted immediate testing of the antifreeze system's freezing point in accordance with NFPA 25, section 5.3.4. The facility contracted with a company to perform a comprehensive inspection and testing of the entire fire sprinkler system, including documentation of antifreeze solution concentration and freezing point. Testing results were documented and stored in the facility's fire safety compliance binder located in the Maintenance Director's office. Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide assessment of all fire protection systems and reviewed all maintenance records to identify any other gaps in required testing or documentation. This review included all wings and areas of the facility where sprinkler systems are installed, with particular attention to areas with antifreeze systems.	10/10/2025

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K0353 SS = D	Continued from page 13 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain and provide documentation of required maintenance for the water-based fire protection systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency could affect the fire sprinkler system. The deficiency could affect all residents, staff, and volunteers using the facility. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility tested the fire sprinkler system on April 18th, and July 14th, 2025, but failed to provide evidence of annual testing of the freezing point of the antifreeze system in accordance with the 2011 NFPA 25, section 5.3.4. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.7.6, 4.6.12.1, 9.7.5, and 2011 NFPA 25, Section 5.3.4	K0353	Continued from page 13 Systemic Changes and Measures Implemented: The facility has implemented a comprehensive fire protection system maintenance schedule that includes: Monthly visual inspections of all sprinkler systems Quarterly flow tests Annual testing of antifreeze systems' freezing points Documentation requirements for all inspections and tests The Maintenance Director has created a digital tracking system to monitor all required testing dates and maintenance schedules for fire protection systems. The facility has established a contract with Western Fire Protection Services for annual comprehensive testing and maintenance of all fire protection systems, including antifreeze system testing. Staff training was conducted on 10/10/2025 to review the new maintenance schedule and documentation requirements. Monitoring and Quality Assurance: The Director of Environmental Services will conduct monthly audits of all fire protection system maintenance records to ensure compliance with testing requirements. The Maintenance Director will maintain a testing schedule log and documentation of all inspections, which will be reviewed monthly by the Safety Committee. Results will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 10/10/2025	
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101	K0355	Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted a facility-wide assessment of all portable fire extinguishers. All fire extinguishers	09/01/2025

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K0355 SS = F	Continued from page 14 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to inspect and maintain portable fire extinguishers in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to inspect and maintain portable fire extinguishers could result in injury or death in the event of a fire. The deficiency affected all portable fire extinguishers throughout the facility. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility failed to provide documentation of inspection and maintenance of portable fire extinguishers including: a) Inspection record keeping – 7.2.4.1 b) Inspections at minimum thirty (30) day intervals – 7.2.1.2 c) Maintenance at intervals not more than one (1) year – 7.3.1.1.1 d) Six (6) year internal examination – 7.3.1.2.1 Observation on 08/28/2025 at 1:05 PM revealed a portable fire extinguisher sitting on a table in the nurse station. The fire extinguisher was partially obstructed and not installed securely on a hanger, in a bracket supplied by the manufacturer, or in a cabinet or wall recess in accordance with the 2010 NFPA 10, Section 6.1.3.4. Observation on 08/28/2025 at 3:20 PM revealed the portable fire extinguisher in the laundry room was missing records of monthly inspections. Observation on 08/28/2025 at 4:10 PM revealed the Class K portable fire extinguisher installed in the kitchen adjacent to the freezer was missing the required warning placard in accordance with the 2010 NFPA 10, section 5.1. Further observations revealed additional portable fire	K0355	Continued from page 14 were immediately secured in appropriate mounting brackets or cabinets, including the unit previously located on the nurse station table. The Class K fire extinguisher in the kitchen was equipped with the required warning placard. A comprehensive inspection was performed on all fire extinguishers, and new inspection tags were installed. The facility contracted a company to conduct required annual maintenance and six-year internal examinations of all portable fire extinguishers on 08/30/2025. Identification of Other Areas with Potential to be Affected: The Maintenance Director completed a 100% audit of all portable fire extinguishers throughout the facility on 08/29/2025, including proper mounting, accessibility, signage, and inspection documentation. This audit identified all areas requiring corrective action to ensure facility-wide compliance with NFPA 10 standards. Systemic Changes and Measures Implemented: The facility has implemented the following measures: Established a new fire extinguisher inspection and maintenance program that includes: Monthly inspections documented on inspection tags and in electronic maintenance logs Annual maintenance by certified contractor Six-year internal examinations tracked through electronic preventive maintenance system Updated facility policy "Fire Safety Equipment Maintenance" to include specific requirements for fire extinguisher inspection, maintenance, and documentation Implemented new electronic tracking system for all fire safety equipment inspections and maintenance Provided in-service training to maintenance staff on 09/01/2025 regarding NFPA 10 requirements Created facility map identifying all fire extinguisher locations with corresponding inspection schedule	

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K0355 SS = F	Continued from page 15 extinguishers throughout the facility were also missing records of monthly inspections. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observations acknowledged the deficiencies. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.3.5.12, 9.7.4.1 and 2010 NFPA 10, Sections 7.2.1.2, 7.2.4.1, 7.3.1.1.1, 7.3.1.2.1	K0355	Continued from page 15 Monitoring and Quality Assurance: The Maintenance Director will conduct weekly audits of fire extinguisher compliance for the first month, then monthly thereafter. The Safety Committee will review audit findings monthly. Results will be reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 09/01/2025	
K0511 SS = E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observations and staff interview, the facility failed to ensure electrical boxes were installed in accordance with the 2011 NFPA 70, National Electric Code. Failure to install electrical receptacles in accordance with the 2011 NFPA 70, National Electric Code could lead to injury or death in the event of exposure to energized electrical systems. The findings could affect all residents and staff utilizing the facility. The findings included five (5) of multiple electrical boxes. The findings were. Observations on 08/28/2025 at 12:50 PM in room 404 revealed an electrical receptacle with no cover plate installed. Observations on 08/28/2025 at 12:55 PM in the Hall 4 bathroom revealed an electrical receptacle with no cover plate installed. Observations on 08/28/2025 08/28/25 at 2:30 PM at the boiler room 2 ceiling revealed an electrical box with exposed wires and no cover plate.	K0511	K-511: Utilities - Gas and Electric Corrective Action Taken: On 08/28/2025, immediately upon identification of the deficient practice, the Maintenance Director installed proper cover plates on the electrical receptacles in room 404, Hall 4 bathroom, and the Admissions and Marketing office. The exposed wires and missing cover plates in boiler rooms 1 and 2 were secured with appropriate electrical box covers. All identified areas were inspected by the Maintenance Director to ensure proper installation and compliance with NFPA 70, National Electric Code requirements. Identification of Other Areas with Potential to be Affected: On 08/29/2025, the Maintenance Director and Assistant Maintenance Director conducted a facility-wide inspection of all electrical receptacles, junction boxes, and electrical installations to identify any similar deficiencies. This comprehensive assessment included all resident rooms, common areas, offices, mechanical spaces, and utility areas. Documentation of this inspection was recorded in the facility maintenance log. Systemic Changes and Measures Implemented: The facility's preventive maintenance program was revised on 09/01/2025 to include monthly inspections of all electrical installations, receptacles, and junction boxes. A new electrical safety policy was implemented on	09/05/2025

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K0511 SS = E	Continued from page 16 Observations on 08/28/2025 08/28/25 at 3:05 PM in the boiler room 1 revealed an open electrical box with a missing cover plate at the ceiling above the door. Observations on 08/28/2025 at 3:40 PM revealed an electrical receptacle with a partially installed cover plate in the Admission and Marketing office. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.5.1.1, 9.1.2, 2011 and NFPA 70 Section 314.25, 406.6	K0511	Continued from page 16 09/01/2025 requiring immediate reporting and same-day correction of any observed electrical hazards. On 09/05/2025, all maintenance staff received comprehensive training on NFPA 70 requirements for electrical installations and proper documentation procedures. An electrical safety checklist was developed and implemented for use during routine facility rounds. The facility's work order system was updated to prioritize electrical safety issues as urgent maintenance items requiring same-day response. Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all electrical installations for the first month, then monthly thereafter, using the newly implemented electrical safety checklist. The Director of Environmental Services will perform independent monthly audits to ensure continued compliance. Results of these inspections and audits will be documented in the maintenance log and reported monthly to the Safety Committee and quarterly to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will review findings and make additional recommendations as needed until substantial compliance is achieved and maintained. Date of Compliance: 09/05/2025	
K0521 SS = F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test fire dampers in accordance with 2010 NFPA 80, Standard for Fire Doors and Other Opening	K0521	Corrective Action Taken: On 08/30/2025, the Maintenance Director contracted with a company to conduct a comprehensive inspection and testing of all fire dampers throughout the facility. The inspection was completed on 09/05/2025, with all fire dampers tested, cleaned, lubricated, and verified for proper operation. Any defective dampers identified during testing were immediately repaired or replaced. Documentation of the inspection, testing, and repairs has been maintained in the facility's fire safety records. Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide assessment of all fire protection systems and equipment on 09/06/2025 to identify any other potential compliance gaps related to inspection and testing requirements. This included a review of	09/10/2025

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K0521 SS = F	Continued from page 17 Protectives. Failure to inspect and maintain fire dampers could result in injury or death in the event of a fire. The deficiency affected all fire dampers throughout the facility. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility failed to ensure fire dampers were tested and inspected one (1) year after installation, and then every four (4) years in accordance with 2010 NFPA 80 section 19.4.1.1. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.5.2, 9.2.1, 2012 NFPA 90A, Section 5.4.8, 2010 NFPA 80, Section 19.4.1.1	K0521	Continued from page 17 maintenance records for all life safety systems to ensure compliance with NFPA standards and manufacturer specifications. Systemic Changes and Measures Implemented: The facility has implemented a comprehensive preventive maintenance program that includes: Creation of a master schedule for fire damper testing at required intervals (one year after installation and every four years thereafter) in accordance with NFPA 80 Section 19.4.1.1 Development of detailed inspection and testing procedures aligned with NFPA 80 requirements Implementation of an electronic maintenance management system to track and schedule all required inspections The Maintenance Director has established a company for ongoing professional inspection and testing services Updated facility policies and procedures regarding fire damper maintenance and testing were developed and implemented on 09/10/2025 Monitoring and Quality Assurance: The Director of Maintenance will conduct monthly audits of the preventive maintenance program to ensure compliance with the testing schedule. The Maintenance Director will maintain a testing log and documentation of all inspections, repairs, and replacements. Results will be reported quarterly to the Safety Committee and QAPI Committee for review and analysis. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 09/10/2025	
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K0712	K-712: Fire Drills Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted an immediate review of all fire drill records for the past 12 months. A new standardized fire drill schedule was implemented	10/24/2025

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K0712 SS = F	Continued from page 18 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of fire drills conducted quarterly on each shift under varied conditions in accordance with 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills quarterly for all shifts and under varied conditions could lead to confusion or delay response resulting in injury or death in the event of a fire emergency. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility failed to provide fire drills quarterly on each shift under varied conditions. Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When fire drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.7.1	K0712	Continued from page 18 ensuring quarterly drills on all shifts (day, evening, and night) under varied conditions. The facility conducted comprehensive fire drills on all three shifts on 08/30/2025, including transmission of fire alarm signals and simulation of emergency fire conditions. For night shift drills between 9:00 PM and 6:00 AM, coded announcements were utilized as permitted by code. Identification of Other Areas with Potential to be Affected: The Maintenance Director and Safety Committee conducted a facility-wide assessment on 08/30/2025 to evaluate all aspects of the fire drill program, including documentation processes, staff knowledge of procedures, and emergency response protocols across all departments and shifts. Systemic Changes and Measures Implemented: Implemented new Fire Drill Policy and Procedure on 09/01/2025 requiring: Quarterly fire drills on each shift with documented varied conditions Electronic tracking system for scheduling and documentation Different scenarios and locations for each drill Specific documentation of transmission method (alarm or coded announcement) Created annual master schedule for fire drills ensuring even distribution across shifts Developed standardized documentation forms capturing all required elements Conducted mandatory in-service training for all staff on 10/24/2025 regarding: Fire drill procedures and expectations	

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K0712 SS = F		K0712	Continued from page 19 Emergency response protocols Documentation requirements Monitoring and Quality Assurance: The Safety Committee will review fire drill documentation monthly to ensure compliance with quarterly requirements and varied conditions. The Maintenance Director will maintain a fire drill tracking log and report findings to the Safety Committee monthly. The Director of Nursing will conduct random staff interviews quarterly to assess knowledge of fire procedures. The QAPI Committee will review fire drill compliance quarterly until substantial compliance is achieved and maintained for four consecutive quarters. Any identified deficiencies will be immediately addressed through corrective action plans. Date of Compliance: 10/24/2025	
K0751 SS = F	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is NOT MET as evidenced by: Based on observation, document review, and staff interview, the facility failed to provide documentation that patient privacy curtains were provided in accordance with the 2012 NFPA 101, Life Safety Code, Section 10.3.1. Failure to provide privacy curtains meeting the performance criteria specified in section 10.3.1 could contribute to flame spread in resident rooms in the event of a fire, leading to injury or death. The deficiency affected multiple resident rooms. The findings were:	K0751	K-751: Draperies, Curtains, and Loosely Hanging Fabrics Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted a facility-wide inspection and inventory of all privacy curtains. All non-compliant privacy curtains were immediately removed and replaced with new NFPA 701 certified privacy curtains that meet the flame propagation performance criteria specified in the 2012 NFPA 101, Section 10.3.1. Documentation of NFPA 701 certification for all new privacy curtains has been obtained and is maintained in the Environmental Services office. The Maintenance Director has verified and documented that all newly installed privacy curtains display the required NFPA 701 certification tags. Identification of Other Areas with Potential to be Affected: The Maintenance Director, in conjunction with Environmental Services staff, conducted a comprehensive assessment of all areas within the facility where privacy curtains, window treatments, and other hanging fabrics are present. This assessment included resident rooms, treatment areas, and any other locations where privacy curtains or draperies are utilized. An inventory database has been created to track all hanging fabrics throughout the facility, including their location, installation date, and NFPA certification status.	09/15/2025

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K0751 SS = F	Continued from page 20 Observation on 08/28/2025 in room 415 revealed a privacy curtain without a NFPA 701 certification in accordance with the 2012 NFPA 101, Section 10.3.1. Further observations revealed that no other privacy curtains contained the NFPA 701 certification. Document review on 08/29/2025 beginning at 9:35 AM revealed the facility failed to provide documentation ensuring the privacy curtains meet the flame propagation performance criteria contained in the 2012 NFPA 101, Section 10.3.1. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections, 19.7.5, 10.3.1	K0751	Continued from page 20 Systemic Changes and Measures Implemented: The facility has implemented the following systemic changes: Revised the Environmental Services policy to require verification of NFPA 701 certification prior to the purchase and installation of any privacy curtains or hanging fabrics. Created a new procurement procedure requiring documented approval from the Maintenance Director for all privacy curtain and drapery purchases. Established a quarterly inspection schedule for all privacy curtains and hanging fabrics. Developed a replacement schedule to ensure curtains are replaced before their NFPA certification expires. Implemented mandatory training for Environmental Services staff and Maintenance personnel on proper documentation and verification of NFPA 701 certification requirements. Monitoring and Quality Assurance: The Maintenance Director will conduct monthly audits of all privacy curtains and hanging fabrics to ensure continued compliance with NFPA 701 requirements. The Environmental Services Supervisor will perform weekly spot checks of randomly selected areas. Results of these audits will be documented in the facility's maintenance tracking system. The Director of Nursing will review audit results monthly, and findings will be reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 09/15/2025	
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K0761	Corrective Action Taken: On 08/30/2025, the Maintenance Director conducted an immediate inspection of all fire doors throughout the facility to ensure proper	09/15/2025

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K0761 SS = F	Continued from page 21 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of an annual maintenance, inspection, and testing program for fire doors in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 80, Standard for Fire Doors and Other Operating Protectives. The deficiency affected all fire doors. Failure to inspect, test, and maintain fire doors could result in injury or death in the event of a fire. The deficiency could impact all residents, staff, and visitors. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility failed to provide documentation of annual maintenance, inspection and testing of all fire doors. The 2010 NFPA 80, Section 5.2.1 requires fire door assemblies to be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections 19.7.6, 4.6.12, 7.2.1.15,	K0761	Continued from page 21 operation and safety. The facility has contracted with a company to conduct a comprehensive inspection and testing of all fire door assemblies in accordance with NFPA 80 requirements. This inspection was completed on 09/02/2025. All identified deficiencies were corrected by 09/05/2025, including adjustment of closing devices, replacement of damaged seals, and repair of latching mechanisms where needed. Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide assessment on 09/03/2025 to identify all fire-rated door assemblies, including but not limited to stairwell doors, corridor fire barriers, and hazardous area doors. A comprehensive inventory and location map of all fire doors has been created and will be maintained in the facility's Life Safety documentation. Systemic Changes and Measures Implemented: The facility has implemented a new Fire Door Inspection and Testing Program effective 09/10/2025, which includes: Monthly visual inspections of all fire doors by maintenance staff Quarterly operational testing of all fire door components Annual comprehensive inspection and testing by qualified personnel The Maintenance Director and two maintenance staff members completed NFPA 80 fire door inspection training on 09/15/2025 New documentation procedures have been implemented, including detailed inspection checklists and maintenance logs. Monitoring and Quality Assurance: The Director of Engineering will conduct monthly audits of fire door inspection documentation to ensure compliance with the new program. The Maintenance Director will perform quarterly reviews of all fire door maintenance records	

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K0761 SS = F	Continued from page 22 and 2010 NFPA 80, Section 5.2.1	K0761	Continued from page 22 and testing documentation. Results will be tracked through the facility's maintenance management system and reported to the Safety Committee monthly and the QAPI Committee quarterly. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 09/15/2025	
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of a testing program for non-hospital grade electrical receptacles installed at resident bed locations in accordance 2012 NFPA 99, Health Care Facilities Code. Failure to provide the required testing and maintenance of non-hospital grade receptacles at resident bed locations could result in injury or death in the event of an electrical receptacle failure. The deficiency could impact all residents and staff utilizing electrical receptacles at resident bed locations. The findings were: Document review on 08/29/2025 beginning at 9:35 AM revealed the facility failed to provide documentation	K0914	K-914: Electrical Systems - Maintenance and Testing Corrective Action Taken: On 08/29/2025, the Maintenance Director conducted an immediate facility-wide inventory of all electrical receptacles at resident bed locations to identify non-hospital grade receptacles. A qualified electrical contractor was engaged by 09/30/2025 to test all non-hospital grade receptacles at resident bed locations according to NFPA 99 requirements. Any receptacles found to be defective during testing were immediately replaced. Documentation of testing results has been compiled in a dedicated electrical testing log maintained in the Maintenance Office. Identification of Other Areas with Potential to be Affected: The Maintenance Director completed a comprehensive assessment of all resident rooms and treatment areas throughout the facility on 08/29/2025 to identify any additional locations with non-hospital grade receptacles requiring testing. A master inventory of all electrical receptacles has been created, documenting location, type, and testing requirements for each receptacle. Systemic Changes and Measures Implemented: The facility has implemented a new Electrical Safety and Testing Policy effective 09/30/2025 that includes: Monthly inspection schedule for all electrical receptacles Annual testing requirements for non-hospital grade receptacles Documentation requirements for all testing and maintenance	10/10/2025

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K0914 SS = F	Continued from page 23 of testing for non-hospital grade electrical receptacles installed at resident bed locations. Receptacles not listed as hospital-grade shall be tested at intervals not exceeding 12 months. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency REF: 2012 NFPA 99 Sections 6.3.3.2 and 6.3.4.1.3	K0914	Continued from page 23 Clear procedures for immediate replacement of defective receptacles The Maintenance Director has created an electronic tracking system to ensure timely completion of required testing, with automated reminders set at 11-month intervals. All maintenance staff completed in-service training on 10/08/2025 regarding: NFPA 99 requirements for electrical receptacle testing Proper documentation procedures Recognition of potential electrical hazards Emergency response procedures for electrical issues Monitoring and Quality Assurance: The Director of Engineering will conduct monthly audits of the electrical testing program to ensure compliance with testing schedules and documentation requirements. Results will be recorded in the facility's maintenance tracking system. The Safety Committee will review testing logs and audit results monthly. The Maintenance Director will report the findings to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance with the set-forth protocols is achieved and maintained for three consecutive quarters. Date of Compliance: 10/10/2025	
K0918 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	K0918	Corrective Action Taken: On 09/01/2025, the Maintenance Director implemented a comprehensive emergency power system testing and maintenance program in accordance with NFPA 110 and NFPA 99 requirements. The following immediate corrective actions were completed: Conducted baseline testing of lead-acid batteries including specific gravity measurements and implemented monthly battery conductance testing protocol	10/10/2025

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K0918 SS = F	Continued from page 24 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 101, Life Safety Code. The deficiency affected all emergency power systems. Failure to provide the required inspection, testing, and maintenance of emergency power systems could lead to injury or death for all residents and staff in the event of an electrical system failure or emergency. The findings were: Document review on 08/29/2025 starting at 8:30 AM revealed the facility's Emergency Power Supply Systems were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following: 1. Maintenance of lead-acid batteries including the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted	K0918	Continued from page 24 Performed a full 30-minute generator load test at 30% of nameplate kW rating while monitoring exhaust gas temperature Scheduled and completed testing of all essential electrical system feeders and circuit breakers Contracted with qualified vendor to conduct comprehensive 36-month load bank testing Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide assessment of all emergency power supply systems, transfer switches, and associated components on 09/02/2025. This review included evaluation of maintenance records, testing procedures, and documentation systems to ensure all emergency power equipment is properly maintained according to NFPA requirements. Systemic Changes and Measures Implemented: The following systemic changes have been implemented: Developed new Emergency Power System Testing & Maintenance Policy incorporating all NFPA 110/99 requirements Created electronic maintenance tracking system with automated scheduling of required testing intervals Implemented detailed testing documentation forms for battery maintenance, generator exercises, and breaker testing Established contract with qualified vendor for annual and 36-month testing requirements Provided comprehensive training to maintenance staff on new procedures and documentation requirements on 09/05/2025 Updated Preventive Maintenance schedule to include all required testing frequencies	

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K0918 SS = F	Continued from page 25 in lieu of the testing of specific gravity when applicable or warranted in accordance with 2010 NFPA 110, section 8.3.7.1. 2. Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, with loading that maintains the minimum exhaust gas temperature as recommended by the manufacturer, or under operating conditions and at not less than 30 percent of the emergency power system nameplate kW rating in accordance with 2010 NFPA 110, section 8.4.2. 3. Diesel-powered emergency power systems that do not meet the requirements of the 2010 NFPA 110, section 8.4.2 shall be exercised annually in accordance with 2010 NFPA 110, section 8.4.2.3. 4. Annual testing and maintenance for essential electrical system feeders and breakers. The facility failed to provide evidence that a program for periodically exercising the components has been established in accordance with manufacturer's recommendations per the 2010 NFPA, section 8.4.7. 5. Level 1 Emergency Power Supply System shall be tested at least once within every 36 months in accordance with the 2010 NFPA 110, section 8.4.9. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1, and 2010 NFPA 110, Sections 8.3.7.1, 8.4.2, 8.4.2.3, 8.4.7, and 8.4.9	K0918	Continued from page 25 Monitoring and Quality Assurance: The Director of Engineering will conduct weekly audits of emergency power system testing records to ensure compliance with established protocols. Monthly reports will be generated documenting completion of required testing and maintenance activities. The Maintenance Director will review all testing documentation weekly and the Administrator will review monthly. Results will be reported quarterly to the Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 10/10/2025	
K0920 SS = E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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	K0920	K-920: Electrical Equipment - Power Cords and Extension Cords Corrective Action Taken: On 08/28/2025, the Maintenance Director immediately removed all daisy-chained power strips from room 409 and the Social Services Office. Non-compliant power strips in rooms 209, 109, and 114 were replaced with UL 1363A listed power strips for Patient-Care-Related-Electrical-Equipment (PCREE). The Maintenance Director conducted a facility-wide inspection to identify and remove any additional non-compliant or daisy-chained power strips.	09/25/2025

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K0920 SS = E	Continued from page 26 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide approved power strips in accordance with 2012 NFPA 99, Health Care Facilities Code. The use of power cords that are not in compliance with 2012 NFPA 99, could increase the risk of electrical failure resulting in injury or death. The deficiency could impact all residents and staff within the affected smoke compartment. The findings were: Observation on 08/28/2025 at 12:45 PM in room 409 revealed multiple power stirps were daisy-chained together. Further observation revealed the facility was connecting Patient-Care-Related-Electrical-Equipment (PCREE) to a non-approved power strip. Power strips for PCREE shall be special purpose relocatable power taps listed as UL 1363A or UL 60601-1. Observation on 08/28/2025 at 2:40 PM revealed multiple power stirps were daisy-chained together in the Social Services Office. Observation on 08/28/2025 starting at 2:45 PM in rooms 209, 109, and 114 revealed the facility was connecting Patient-Care-Related-Electrical-Equipment (PCREE) to a non-approved power strips. Power strips for PCREE shall be special purpose relocatable power taps listed as UL 1363A or UL 60601-1. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, 10.2.3.6, 10.2.4	K0920	Continued from page 26 Identification of Other Areas with Potential to be Affected: On 08/29/2025, the Maintenance Director and Safety Officer conducted a comprehensive facility-wide assessment of all resident rooms and office areas to identify any non-compliant power strips or improper electrical connections. This inspection included verification of UL listings on all power strips used for PCREE and identification of any daisy-chained configurations. Systemic Changes and Measures Implemented: The facility has implemented a new electrical safety policy requiring all power strips used for PCREE to be UL 1363A or UL 60601-1 listed, effective 08/30/2025. The Maintenance Department has created an inventory of all power strips in use, documenting their location, UL listing, and intended use. Staff education was conducted on 09/25/2025 regarding proper use of power strips, including prohibition of daisy-chaining and requirements for PCREE-approved power strips. New procurement procedures require verification of proper UL listing before purchasing any power strips. Warning labels have been applied to all power strips indicating their approved use (PCREE vs. non-PCREE). Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of all resident rooms and common areas to ensure compliance with power strip requirements. The Safety Officer will perform monthly audits of power strip usage and documentation. Results will be recorded in the maintenance log and reviewed during monthly Safety Committee meetings. The Director of Nursing will ensure compliance in clinical areas through weekly rounds. The Maintenance Director will report monitoring results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial	

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K0920 SS = E		K0920	Continued from page 27 compliance with the set-forth protocols is achieved. Date of Compliance: 09/25/2025	
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by:	K0923	K-923: Gas Equipment - Cylinder and Container Storage Corrective Action Taken: On 08/28/2025, immediately upon identification of the deficiency, all unsecured oxygen cylinders in Room 105 and the Physical Therapy room were properly secured in approved cylinder holders/carts. The Maintenance Director conducted a facility-wide inspection of all areas where medical gas cylinders are stored or in use to ensure proper securing mechanisms were in place. All medical gas cylinders throughout the facility were verified to be properly secured in accordance with NFPA 99 Sections 11.6.2.3 and 11.7.3.2. Identification of Other Areas with Potential to be Affected: On 08/28/2025, the Maintenance Director and Director of Nursing conducted a comprehensive facility-wide audit of all departments and resident care areas where medical gas cylinders may be present or stored. This audit included, but was not limited to, all resident rooms, therapy areas, storage rooms, and clinical support areas to identify any additional unsecured cylinders or improper storage conditions. Systemic Changes and Measures Implemented: The facility's medical gas cylinder storage and handling policy was revised on 08/29/2025 to include specific requirements for proper cylinder securing and storage. Additional cylinder holders and secure storage carts were purchased and installed in all areas where oxygen cylinders are routinely used or stored. Mandatory in-service training was conducted for all clinical staff, therapy staff, and maintenance personnel by 10/10/2025 regarding proper medical gas cylinder storage, handling, and securing requirements per NFPA 99. New signage was installed in all areas where medical	10/10/2025

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K0923 SS = D Bldg. 01	Continued from page 28 Based on observation and staff interview, the facility failed to properly protect gas cylinders in accordance with 2012 NFPA 99, Healthcare Facilities Code. Failure to properly protect cylinders from damage could result in injury or death in the event of an accident. The deficiency could affect all residents, staff, and volunteers within the Activities area. The findings were: Observation on 08/28/2025 at 3:42 PM revealed an oxygen gas cylinder stored on top of a table or desk inside of room 105. The freestanding cylinder was not chained or stored in a proper stand or cart in accordance with 2012 NFPA 99. Observation on 08/28/2025 at 3:45 PM revealed two (2) oxygen gas cylinders stored on top of a table or desk inside of the Physical Therapy room. The freestanding cylinders were not chained or stored in a proper stand or cart in accordance with 2012 NFPA 99. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99 Sections 11.6.2.3, 11.7.3.2	K0923	Continued from page 28 gas cylinders are stored or used, indicating proper storage requirements and safety precautions. A medical gas cylinder inventory and security checklist was implemented for daily use by department supervisors. Monitoring and Quality Assurance: The Director of Nursing and Maintenance Director will conduct weekly audits of all areas where medical gas cylinders are stored or in use to ensure continued compliance with NFPA 99 requirements. These audits will be documented using the Medical Gas Cylinder Security Audit Tool. The Safety Committee will review audit findings monthly, and results will be reported quarterly to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Any identified deficiencies will be corrected immediately and additional staff education provided as needed. Date of Compliance: 10/10/2025	

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 08/28/2025 and 08/29/2025. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		10/01/2025
E0006 SS = F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E0006	E-6: Maintain and Annual EP Updates Corrective Action Taken: On 8/29/2025, the facility's Emergency Preparedness Plan (EPP) was revised to include a comprehensive risk assessment specifically addressing missing residents. The addition of all items we have done have been updated in the EPP. The risk assessment now includes detailed protocols for prevention of elopement, immediate response procedures when a resident is discovered missing, search protocols, notification requirements, and documentation processes. The facility's EPP Committee, led by the Director of Maintenace and Administrator, conducted a thorough review and update of the all-hazards risk assessment to ensure full compliance with §483.73(a)(1)-(2). Identification of Other Areas with Potential to be Affected: On 8/29/2025, the facility conducted a comprehensive review of all components of the Emergency Preparedness Plan to identify any other areas requiring enhancement. This review included evaluation of all emergency response protocols, facility security measures, an elopement binder, and wander guard/elopement prevention systems to ensure alignment with missing resident protocols. All resident care areas were assessed for potential elopement risks. Systemic Changes and Measures Implemented: The following systemic changes have been implemented: The EPP established a quarterly review schedule for the all-hazards risk assessment, with the first review completed on 10/10/2025.	10/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

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E0006 SS = F	Continued from page 1 identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[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. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with an all-hazards risk assessment that includes missing residents in accordance with §483.73(a)(1)-(2). Failure to provide a risk assessment that includes missing residents could delay response in the event of a missing resident. The findings were: Review of the facility EPP on 08/28/2025 starting at 4:30 PM revealed that the facility had included an all-hazards risk assessment, but failed to include a risk assessment for missing residents. Interview with the facility maintenance manager, the director of nursing, and the facility administrator, along with document review at the time of observation, acknowledged the deficiency.	E0006	Continued from page 1 Updated missing resident protocols have been incorporated into the new employee orientation and annual staff training. Elopement Binder information is accessible to all staff in the ¾ Charting Room with updated documentation of this practice in the EPP. Elopement drills have been implemented to test response procedures Door alarm testing protocols have been enhanced with weekly checks QAPI committee will review all elopement risk assessments quarterly Monitoring and Quality Assurance: The Safety Officer will conduct monthly audits of the missing resident risk assessment protocols and associated documentation. Results will be tracked and trended through the facility's QAPI program. The Administrator will review audit results monthly, and findings will be reported to the quarterly QAPI committee. The QAPI committee will analyze data for patterns and opportunities for improvement until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 10/10/2025	

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E0006 SS = F	Continued from page 2 Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency.	E0006		
E0039 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 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	E0039	Corrective Action Taken: On 09/01/2025, the facility's Emergency Preparedness Committee, led by the Administrator and including the Director of Nursing and Maintenance Manager, conducted a comprehensive review of the Emergency Preparedness Plan (EPP) testing requirements. The facility immediately scheduled and conducted a tabletop exercise on 09/15/2023, led by the Emergency Preparedness Coordinator, which included a clinically-relevant scenario involving a prolonged power outage during extreme weather conditions. Identification of Other Areas with Potential to be Affected: The Emergency Preparedness Committee conducted a facility-wide assessment on 10/05/2025 to identify all areas requiring emergency preparedness testing and documentation. This review included evaluation of all emergency response protocols, staff training records, and documentation systems for tracking EPP exercises. Systemic Changes and Measures Implemented: The facility has implemented a new Emergency Preparedness Testing Schedule, effective 10/05/2025, which requires: Full-scale or facility-based functional exercise to be conducted in April of each year Additional exercise (tabletop, mock disaster, or second full-scale) to be conducted in October of each year Monthly review of testing schedule by Emergency Preparedness Committee Created new EPP Testing Documentation System that includes: Electronic calendar alerts for scheduled exercises Standardized documentation forms for all types of exercises	10/15/2025

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E0039 SS = F	Continued from page 3 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 (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	E0039	Continued from page 3 After-action review templates Tracking log for all emergency events and exercises Revised Emergency Preparedness Policy to include: Clear definitions of required exercise types Specific documentation requirements Process for scheduling and conducting exercises Requirements for after-action reviews Monitoring and Quality Assurance: The Emergency Preparedness Coordinator will maintain a testing schedule tracker and provide monthly reports to the Administrator. The Administrator will review compliance with testing requirements monthly. The Quality Assurance Performance Improvement (QAPI) Committee will review emergency preparedness testing compliance quarterly. The Emergency Preparedness Committee will conduct quarterly audits of: Testing schedule compliance Exercise documentation completeness After-action review implementation Staff participation records Results will be reported to the QAPI Committee quarterly. The QAPI Committee will monitor until substantial compliance is achieved and maintained for two consecutive quarters. Date of Compliance: 10/15/2025	

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E0039 SS = F	Continued from page 4 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 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	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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E0039 SS = F	Continued from page 5 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 [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	E0039		

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E0039 SS = F	Continued from page 6 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (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	E0039		

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E0039 SS = F	Continued from page 7 plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, 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	E0039		

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E0039 SS = F	Continued from page 8 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the	E0039		

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E0039 SS = F	Continued from page 9 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test the emergency plan at least twice per year, including unannounced staff drills using emergency procedures in accordance with §483.73(d)(2). Failure to conduct training exercise at least twice annually to test EPP could leave the facility inadequately prepared in the event of an emergency. The findings were: Review of the facility EPP on 08/28/2025 starting at 4:30 PM revealed that the facility had failed to perform EPP testing at least twice annually. Documentation revealed the facility experienced and actual emergency in August, 2024, that required activation of their emergency plan. Further documentation review revealed the facility failed to conduct an additional annual exercise in accordance with §483.73(d)(2)(ii) that may include, but is not limited to the following: 1. A second full-scale exercise that is community-based or an individual, facility based functional exercise;	E0039		

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E0039 SS = F	Continued from page 10 or 2. A mock disaster drill; or 3. A tabletop exercise or workshop that is led by a facilitator Interview with the facility maintenance manager, the director of nursing, and the facility administrator acknowledged the deficiency. Interview with facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency.	E0039		
E0041 SS = F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)	E0041	Corrective Action Taken: On 08/30/2025, the Maintenance Director conducted a comprehensive review of all emergency power system testing and maintenance requirements. The following immediate corrective actions were implemented: - Established monthly lead-acid battery testing protocol including specific gravity measurements and conductance testing - Implemented 30-minute monthly diesel generator testing under minimum 30% nameplate kW rating load - Scheduled annual testing for diesel-powered emergency power systems - Created documentation system for essential electrical system feeders and breakers maintenance - Scheduled 36-month Level 1 Emergency Power Supply System testing Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a facility-wide assessment on 08/31/2025 to identify all emergency power systems and components requiring regular testing and maintenance. This assessment included review of: - All backup power systems and components - Battery systems - Generator systems - Essential electrical system feeders and breakers - Emergency power distribution systems	09/15/2025

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E0041 SS = F	Continued from page 11 Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013.	E0041	Continued from page 11 Systemic Changes and Measures Implemented: 1. Developed comprehensive Emergency Power Systems Testing and Maintenance Program, effective 09/01/2025, including: - Monthly battery testing schedule with specific gravity/conductance testing requirements - Monthly generator load testing protocols at minimum 30% nameplate rating - Annual diesel system testing procedures - Essential electrical system maintenance schedules - 36-month Level 1 system testing requirements 2. Created electronic maintenance tracking system to ensure compliance with all NFPA 110 and NFPA 99 requirements 3. Implemented staff training program on 09/05/2025 for maintenance personnel on new testing/maintenance protocols Monitoring and Quality Assurance: The Maintenance Director will conduct weekly audits of all emergency power system testing and maintenance records. The Director of Engineering will perform monthly oversight reviews of testing documentation and maintenance logs. Results will be reported monthly to the Safety Committee and quarterly to the QAPI Committee. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Compliance: 09/15/2025	

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E0041 SS = F	Continued from page 12 (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 101, Life Safety Code in accordance with §483.7(e)(2). Failure to provide the required inspection, testing, and maintenance of emergency power systems could lead to injury or death for all residents and staff in the event of an electrical system failure or emergency. The findings were: Document review on 08/29/2025 starting at 8:30 AM revealed the facility's Emergency Power Supply Systems were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following:Maintenance of lead-acid batteries including 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 2010 NFPA 110, section 8.3.7.1.Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, with loading that maintains the minimum exhaust gas temperature as recommended by the manufacturer, or under operating conditions and at not less than 30 percent of the emergency power system nameplate kW rating in accordance with 2010 NFPA 110, section 8.4.2.Diesel-powered emergency power systems that do not meet the requirements of the 2010 NFPA 110, section 8.4.2 shall be exercised annually in accordance	E0041		

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E0041 SS = F	Continued from page 13 with 2010 NFPA 110, section 8.4.2.3.Annual testing and maintenance for essential electrical system feeders and breakers. The facility failed to provide evidence that a program for periodically exercising the components has been established in accordance with manufacturer's recommendations per the 2010 NFPA 110, section 8.4.7.Level 1 Emergency Power Supply System shall be tested at least once within every 36 months in accordance with the 2010 NFPA 110, section 8.4.9.Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager, the director of nursing, and the facility administrator at the time of exit confirmed the deficiency.	E0041		