STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Rehabilitation and Wellness	**3128 Boxelder Dr , Cheyenne, Wyoming, 82001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 03/26/2026 and 03/27/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, three story building with a basement of a Type II (222), and Type II (111) construction built in 1966 and 1972. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 146 certified Medicare and Medicaid beds with a census of 83 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0351 SS = F Bldg. 01	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.	K0351	K 351 CORRECTIVE ACTION Closet in rooms #311, 210, 216, 231 the activities closet on 2nd floor and activity closet on 3rd floor and the rehab room closet were all cleaned on 4/3/26 allowing 18 inches around sprinkler head by the Maintenance Director. A fire sprinkler was installed in the 3rd floor housekeeping closet by room 302 on 4/14/26 by the vendor. The sprinkler in the 2nd floor auxiliary dining area was moved to be 4 inches away from the wall on 4/14/26 by the vendor. IDENTIFICATION OF OTHERS	05/08/2026

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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K0351 SS = F Bldg. 01	Continued from page 1 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 observation and staff interview, the facility failed to ensure proper installation of the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13, 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 multiple fire sprinklers throughout the facility. The deficiency could affect all residents, staff, and volunteers in the facility. The findings were: Observation on 03/26/2026 starting at 9:23 AM revealed the facility failed to provide adequate clearance between the fire sprinkler system and the storage in multiple resident room closets including rooms 311, 210, 216, 231, the activities closets on the 2nd and 3rd floor, and the rehab gym closet. The storage was within eighteen inches (18") of the ceiling-mounted fire sprinkler deflectors creating an obstruction to sprinkler discharge pattern development. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, 2010 NFPA 13 Section 8.5.6 Observation on 03/26/2026 starting at 9:32 AM in the closet by room 302 revealed, that no sprinkler could be identified as being within it. It is possible that a sprinkler is located above the duct work, but then the duct work would obstruct with the distribution of water from the sprinkler head. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, 2010 NFPA	K0351	Continued from page 1 The closets in the center were inspected on 4/3/26 to ensure that the storage allows for 18 inches of space around the sprinkler head. Any identified closets were corrected. The Maintenance team audited the housekeeping closet for missing fire sprinklers on 3/27/26. None were found to be missing. The Maintenance team audited the axillary dining closets to ensure that all sprinklers are at least 4 inches from the wall on 3/27/26. No concerns were identified. SYSTEMIC CHANGE The Maintenance Team wrote above the red line in the closets "NOTHING ABOVE THIS LINE" in all closets to remind staff, residents and visitors not to store anything within 18 inches of the sprinkler head. In-service education was provided to the Center staff on 4/10/26 related to ensuring that fire sprinklers in the closet have at least an 18 inch clearance. The Maintenance Team was educated on the requirement of every housekeeping closet to have a fire sprinkler on 4/3/26 by the NHA. The Maintenance Director/designee checks each housekeeping closet monthly to verify that there is a fire sprinkler in the closet. In-service education was provided to the Maintenance team related to the requirement of the sprinkler to be 4 inches from the wall on 4/3/26. The Maintenance Director/designee checks each axillary dining closet monthly to verify that the fire sprinkler is 4 inches from the wall. MONITORING	05/08/2026

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K0351 SS = F Bldg. 01	Continued from page 2 13 Section 8.6.5 Observation on 03/26/2026 starting at 10:57 AM in the closet in 2nd floor auxiliary dining revealed, that the sprinkler was approximately 1 3/4" from the wall. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, 2010 NFPA 13 Section 8.6.3.3	K0351	Continued from page 2 The Maintenance Director will check closets weekly to validate that no closets have storage within 18 inches of the sprinkler head and report findings to the QAPI Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue. The Maintenance Director checks the housekeeping closets monthly to validate that each closet has a fire sprinkler and reports the findings to the QAPI Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue. The Maintenance Director checks the axillary dining closets monthly to validate that the fire sprinkler is 4 inches from the wall and reports the findings to the QAPI Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026
K0223 SS = E Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0223	K 223 CORRECTIVE ACTION The exit door to the stairwell by 318, the north exit door in the therapy gym, the storage room door near room 107 and the door to room 113 were repaired on 4/8/26 and now latch properly by the Maintenance Director. IDENTIFICATION OF OTHERS The Maintenance Team checked all storage room doors to ensure that they latch properly on 3/27/26. No other doors did not latch. SYSTEMIC CHANGE The Maintenance Team was provided in-service education by the NHA on related to ensuring that all storage room doors latch on 4/3/26.	05/08/2026

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K0223 SS = E Bldg. 01	Continued from page 3 failed to ensure doors in a stairway enclosure or hazardous area enclosure are self-closing and kept in the closed position unless held open by a release device in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure self-closing doors close and latch could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected four (4) of multiple doors and could potentially affect all residents, staff, and visitors. The findings were: Observations on 03/26/2026 at starting at 9:54 AM revealed the following self-closing doors were equipped with closing devices and failed to close and latch, keeping the doors in the closed position: 1. Stairwell door by room 318 failed to latch when dropped at 9:54 AM 2. Cross corridor rated fire doors on the north side of the rehab gym failed to latch at 12:38 PM 3. Room 107 being used as a storage room failed to latch at 1:00 PM 4. Room 113 being used as a storage room failed to latch at 1:17 PM Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7.1, 7.2.1.8	K0223	Continued from page 3 The Maintenance Team audits all storage room doors and verifies that all the door latch appropriately monthly. Any door that do not latch are corrected at that time. MONITORING The Maintenance Director reports his finding of the monthly audits of the storage room doors to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026
K0325 SS = E Bldg. 01	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing	K0325	K 325 CORRECTIVE ACTION The Alcohol-based hand-rub was moved by the Maintenance Director and is now stored with less than 5 gallons per smoke compartment and less then 20 gallons in the yellow fire cabinet as of 3/27/26. IDENTIFICATION OF OTHERS All closets were searched for additional	05/08/2026

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K0325 SS = E Bldg. 01	Continued from page 4 * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store Alcohol-Based Hand-Rub (ABHR) in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 30, Flammable and Combustible Liquids Code . Failure to store ABHR as required could contribute to the spread of smoke or fire, resulting in injury or death during an emergency. The deficiency affected two (2) of several storage rooms in the facility, and could potentially affect residents, staff, and visitors within the smoke compartment. The findings were Observation on 03/26/2026 at 1:10 PM in the EVS storage closet and the housekeeping storage closet in the basement, revealed that there was approximately 99L (26.1 Gallons) of ABHR stored between the two closest in the same smoke compartment. Neither room was rated, but doors did have closures and the closets were sprinklered. However, the control area was also below the grade plane in the basement. ABHR is considered a Class 1 liquid, and as such is not permitted in basement storage locations. 2012 NFPA 30 definition of basement "For the purposes of this code, a story of a building or structure having one-half or more of its height below ground level and to which access for fire-fighting purposes is restricted."	K0325	Continued from page 4 alcohol-based hand-rub on 3/27/26 by the Maintenance Staff. Any additional hand rub found was either disposed of or stored in an approved area. SYSTEMIC CHANGE In-service education was provided to the Maintenance, Housekeeping and Central supply staff related to proper storage of alcohol-based hand rub on 3/30/26 by the administrator. The Maintenance Director/designee audits the alcohol-based hand rub storage areas once a month to ensure that the storage area is limited to the appropriate amount of alcohol-based hand rub. MONITORING The Maintenance Director reviews the results of the audits of the alcohol-based hand rub storage areas with the QAPI Committee monthly to review any negative patterns or trends for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026

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K0325 SS = E Bldg. 01	Continued from page 5 Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2.3(7) 2012 NFPA 30 Sections 3.3.4, 9.3.6, 9.6.2.1(7), 9.7.1, 9.7.2, 9.7.3 Tables 9.6.2.1, 9.7.2	K0325		05/08/2026
K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K0222	K 222 CORRECTIVE ACTION A delayed egress sign was placed on the stairwell door on 4/3/26 by the Maintenance Director. IDENTIFICATION OF OTHERS The Maintenance Team checked all other exit doors requiring delayed egress signs to ensure the signage is in place on 3/30/26. All signs were in place. SYSTEMIC CHANGE The Maintenance Team was provided in-service training by the NHA on 3/30/26 regarding all exit doors requiring delayed egress signage. The Maintenance Director/designee checks all delayed egress doors for proper signage monthly. If a door is found to be without the correct signage, it is corrected at that time. MONITORING The Maintenance Director reports the findings of the delayed egress signage to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026

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K0222 SS = D Bldg. 01	Continued from page 6 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based upon observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress resulting in injury or death during an emergency. the deficiency affected one (1) of numerous exits in the facility. Observation on 03/26/26 at 9:54 AM at the 3rd floor secured unit stairwell door revealed that the delayed egress was not provided with signage as required by the Life Safety Code. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref. 2012 NFPA 101: Section 19.2.2.2.4(2); 7.2.1.6.1.1 (4)	K0222		05/08/2026

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K0271 SS = D Bldg. 01	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 visitors. The findings were: Observation on 03/26/2026 at 1:22 PM revealed the concrete at the exit door on the southeast side of the building near the rehab gym and room 118 has an abrupt change in elevation of walking surface in excess of one-quarter inch (1/4") 2012 NFPA 101, Life Safety Code, specifies that abrupt changes in elevation of walking surfaces shall not exceed one-quarter inch (1/4”). The rise in the concrete was enough that it prevented the left door (from the inside) from fully opening. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.6	K0271	K 271 CORRECTIVE ACTION The uneven surface by the exit door was repaired by grinding the concrete down in order for the door to swing fully by the Maintenance Director on 4/16/26. IDENTIFICATION OF OTHERS The Maintenance Team checked the walking surfaces outside all of the exit doors that prevent the exit door from opening properly on 4/3/26 to ensure there were no uneven walking surfaces. None were found. SYSTEMIC CHANGE In-service education was provided to the Maintenance Team on 4/3/26 by the NHA regarding the requirement for the walking surfaces to be even outside exit doors. The Maintenance Director/designee checks the walking surfaces outside each exit door monthly and validates that the surface is not uneven. Any concerns identified are corrected. MONITORING The Maintenance Director reports his finding of the exit door walking surfaces to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026
K0291 SS = D Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is	K0291	K 291 CORRECTIVE ACTION The emergency lighting battery in the therapy gym	05/08/2026

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K0291 SS = D Bldg. 01	Continued from page 8 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 observation and staff interview, the facility failed to provide emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide emergency lighting as required could result in injury or death during an emergency. The deficiency affected one (1) of several battery back-up lights in the facility and could potentially affect residents, staff, and visitors in the area. The findings were: Observation on 03/26/2026 at 12:35 PM on the north wall of the rehab gym on the first floor revealed that a battery powered light failed when put into test mode. In an emergency, failure of the battery-powered lighting could delay or prevent egress from the space. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.9.1, 7.9	K0291	Continued from page 8 was replaced on 3/28/26 by the Maintenance Director. IDENTIFICATION OF OTHERS The Maintenance Director checked all emergency lighting to ensure it functioned properly on 3/28/26. No other concerns identified. SYSTEMIC CHANGE The Maintenance team was educated on 3/30/26 related to ensuring all emergency lighting is functioning properly. The Maintenance Director/designee checks emergency lighting monthly to verify it is working correctly and any concerns are corrected. MONITORING The Maintenance Director reports his findings on the emergency lighting audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K0321	K 321 CORRECTIVE ACTION The door in the Activity room bathroom storage area has had self-closing hinges added by the Maintenance Director on 4/8/26. IDENTIFICATION OF OTHERS The Maintenance Director checked all storage room doors to verify that a self-closure or self-closing hinges were present and functions appropriately on 3/27/26. No other concerns were identified. SYSTEMIC CHANGE	05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535013	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Rehabilitation and Wellness	**3128 Boxelder Dr , Cheyenne, Wyoming, 82001**

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K0321 SS = D Bldg. 01	Continued from page 9 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas are protected by a door with a closure device in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors protecting hazardous areas could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected one (1) of multiple hazardous storage areas. The deficiency affected all residents and staff in the area. The findings were: Observation on 03/26/2026 at 11:57 PM revealed the bathroom in the activities/library, was being used for storage and did not have a door closure on the door. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.2, 8.4.3.5	K0321	Continued from page 9 The Maintenance Director was educated on 3/30/26 related to the requirement for self-closure on storage area doors. The Maintenance Director/designee audits all storage area doors monthly to verify self-closure devices in place and functioning properly. MONITORING The Maintenance Director report results of self-closures on storage closets to the Quality Assurance Performance Improvement Committee monthly for review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026

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K0353 SS = D Bldg. 01	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 _____ 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 the water-based fire protection systems in accordance with 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency impacted the immediate location of each observation, as well as the adjacent corridor. The deficiency could affect all residents, staff, and visitors in the affected smoke compartment. The findings were: Observation on 03/26/2026 at 11:15 AM in the closet between rooms 222 and 220 revealed the sprinkler head had been painted on the frame. And was potentially unable to be removed if needed for maintenance. Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of	K0353	K 353 CORRECTIVE ACTION The sprinkler head in the clean utility room near room 222/220 was replaced by the vendor on 4/13/26. IDENTIFICATION OF OTHERS The Maintenance Director inspected the other sprinkler heads in the facility to see if any others had paint or mud on them on 4/3/26. None were identified. SYSTEMIC CHANGE In-service education was provided to the Maintenance Team related to ensuring that all sprinkler heads are free from paint or mud on 3/30/26 by the NHA. The Maintenance Director/designee checks the sprinkler heads in the facility to verify that all are free of paint or mud monthly. If any are identified it is corrected. MONITORING The Maintenance Director reports his findings related to ensuring sprinkler heads are free of paint or mud monthly to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026

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K0353 SS = D Bldg. 01	Continued from page 11 exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.7.5 2011 NFPA 25, Sections 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4	K0353		05/08/2026
K0920 SS = D Bldg. 01	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 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, photo evidence, and staff interview, the facility failed to provide appropriate electrical receptacles in accordance with NFPA 101, Life Safety Code and NFPA 70, National Electrical Code. Failure to provide appropriate electrical receptacles as required could result in the failure of equipment. The deficiency affected one (1) room and could potentially affect the staff in the room. The findings were: Observation on 03/26/2026 at 11:40 AM in the social services office revealed a flexible cord power strip being used as fixed wiring. Flexible cord power strip was plugged into receptacle and wrapped around the room where a window air conditioner unit was plugged into it. Flexible cords and cables shall not be used as substitute for the fixed wiring of a structure.	K0920	K 920 CORRECTIVE ACTION The power strip was removed from air conditioner in Social Service Office by the maintenance director 3/27/26. A new outlet was installed on 4/7/26 for the use of air conditioner by the vendor. IDENTIFICATION OF OTHERS The Maintenance Director checked all other air conditioner units to verify none were plugged into power strip on 3/27/26. None were identified. SYSTEMIC CHANGE The Maintenance team was provided education related to ensuring air conditioning units are plugged directly into outlet and power strips are not used as extension cords on 3/30/26by NHA. The Maintenance Director/designee monitors air conditioning units to verify that all are plugged directly into outlet monthly. MONITORING The Maintenance Director reports his findings related to air conditioner units being plugged directly into the outlet to the Quality Assurance Performance Improvement Committee for their review and resolution. These reports will continue monthly for 3 months unless the QAPI Committee deems it prudent to continue.	05/08/2026

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K0920 SS = D Bldg. 01	Continued from page 12 Interview with the facility maintenance manager and regional manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101, Sec. 19.5.1.1, 9.1.2 2011 NFPA 70, Sec. 400.8 (1)	K0920		05/08/2026

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E0000	Initial Comments An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 03/26/2026 and 3/27/2026. Based upon the findings of the survey, it was determined the facility was in compliance with all requirements of 42 CFR 483.73.	E0000		04/09/2026

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