STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535032	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Cheyenne	**1330 Prairie Ave , Cheyenne, Wyoming, 82009**

(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 09/23/2025 and 9/24/2025. 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 one story building with a Type V (111) construction with plan approval in 1987 and 2009. The building was equipped with a supervised wet sprinkler system with a dry sprinkler branch, and an addressable fire alarm system. The facility had 160 certified Medicare and Medicaid beds with a census of 115 residents. The findings that follow demonstrate noncompliance with 42 CFR 48.90.	K0000		12/10/2025
K0353 SS = F 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	K0353	Contractor completed the quarterly sprinkler inspection, all quarterly reports from 2024 to present, moving forward will be available in building at time of inspection.	12/10/2025

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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K0353 SS = F Bldg. 01	Continued from page 1 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 09/23/2025 starting at 2:00 PM revealed the facility failed to provide documentation of testing and maintenance for Fire Protection Systems in accordance with 2011 NFPA 25. The facility failed to provide documentation for testing of the following fire automatic sprinkler systems: a) Semi-annual Water flow alarm devices – 5.3.3.2 b) Semi-annual Supervisory signal devices – 13.3.3.5 c) Quarterly – Priming Water 13.4.4.2.1 d) Quarterly – Low air Alarm 13.4.4.2.6 Interview with the facility maintenance manager at the time of the observation acknowledged the deficiencies. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5 2010; NFPA 25, Sections 5.3.3.2; Tables 5.1.1.2, 13.1	K0353		12/10/2025
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each	K0712	The facility will ensure each shift has fire drills at unexpected times each quarter, along with monthly activation of alarms.	12/10/2025

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K0712 SS = F Bldg. 01	Continued from page 2 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 deficiency could affect all residents, staff, and visitors. The findings were: Document review on 09/23/2025 starting at 2:00 PM 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 and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.7.1	K0712		12/10/2025
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K0761	During visit failed to provide documentation on fire doors, 2024 documentation was located on tels, which was completed 11/2024, followed up by completing fire door inspection 11/6/2025.	12/10/2025

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K0761 SS = F Bldg. 01	Continued from page 3 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 09/23/2025 starting at 2:00 PM 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 and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager 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, and 2010 NFPA 80, Section 5.2.1	K0761		12/10/2025
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall	K0918	Maintenance performed a 4 hour load test with the transfer switch engaged, moving forward this test will be performed every 36 months. Contractor performed annual load bank test and fuel sample. Maintenance performed a lead acid battery test, and this will be performed every month from this time forward.	12/10/2025

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K0918 SS = F Bldg. 01	Continued from page 4 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 in the event of an electrical system failure or emergency. The deficiency could affect all residents, staff and visitors. The findings were: Document review on 09/23/2025 starting at 2:00 PM 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	K0918		12/10/2025

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K0918 SS = F Bldg. 01	Continued from page 5 gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 2. Level 1 Emergency Power Supply System shall be tested at least once within every 36 months. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager 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		12/10/2025
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.	K0222	Adjust door tension with locking magnet on door 300 to achieve 15LBF. Weekly tels check to ensure compliance.	12/10/2025

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K0222 SS = D Bldg. 01	Continued from page 6 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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 on 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 result in injury or death during an emergency. The deficiency affected exit doors equipped with delayed egress throughout the facility. The findings were: Observation on 9/23/2025 at 10:33 AM at the exit door for the 300 hall, revealed the delayed egress locking system failed to operate as designed. When tested the required force to activate an irreversible process to release the door, was in excess of 30 lbf. The force shall not be required to exceed 15 lbf. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency.	K0222		12/10/2025

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K0222 SS = D Bldg. 01	Continued from page 7 Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(3)(a)	K0222		12/10/2025
K0223 SS = D 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 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 three (3) of multiple doors. The findings were: Observations on 09/23/2025 at 10:47 AM revealed the soiled linen room on hall 400, was protected with a self-closing door. Further observation revealed the self-closing door failed to close and latch, keeping the door in the closed position. Observations on 09/23/2025 at 12:05 PM revealed the boiler room 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	K0223	Maintenance staff replaced the self closing device on the boiler room door, and ensured it closed properly. Maintenance staff repaired the door between the dining and dish room and adjusted the self closing device to keep the door in a closed position and ensured there is no longer a gap at the top of the door. Maintenance staff removed all paint covering up fire door labels. Moving forward maintenance will do weekly check on all kitchen doors and self closing devices and ensure paint is not covering any door labels.	12/10/2025

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K0223 SS = D Bldg. 01	Continued from page 8 the door in the closed position. Observations on 09/23/2025 at 1:37 PM revealed the door between the dining and dishwashing rooms was protected with a self-closing door. Further observation revealed the fire door label was painted over and the self-closing door failed to latch, keeping the door in the closed position. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager 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		12/10/2025
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 09/23/2025 at 10:12 AM revealed the exit path from the 200 hall to the public way 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”).	K0271	Replace sidewalk sections on the 200 hall exit. Replacement will be finished by November 28, 2025. Moving forward we will check sidewalks weekly as part of EGRESS to avoid future issues.	12/10/2025

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K0271 SS = D Bldg. 01	Continued from page 9 Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.6	K0271		12/10/2025
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. 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	K0321	Self closing device was installed on the 200 mechanical door, also we will check this door on a weekly basis with all other doors. Weekly tels check to be completed.	12/10/2025

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K0321 SS = D Bldg. 01	Continued from page 10 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 fire barrier having a 1-hour fire resistance rating (with 3/4 -hour fire rated doors) in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire rated fire 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 doors. The deficiency affected all residents and staff using the hazardous area. The findings were: Observation on 09/23/2025 at 9:57 AM revealed the rated mechanical room door on the 200 hall, did not have a self-closing device installed. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7, 8.3, 2010 NFPA 80 Sections, 5.2.4.2 (1), 6.1.4.2.1	K0321		12/10/2025
K0324 SS = D Bldg. 01	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	K0324	Contractor inspected hoods quarterly, moving forward these inspection reports will be available at time of survey.	12/10/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0324 SS = D Bldg. 01	Continued from page 11 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 the kitchen hood extinguishing system inspections and failed to provide evidence of kitchen hood inspections for grease build up 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 have the kitchen extinguishing system inspected and the kitchen hood cleaned of grease build ups could result in injury or death in the event of a fire. The deficiency could affect the entire facility. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 09/23/2025 at 2:00 PM revealed that one of the two (2) inspections of the kitchen hood had been completed in the past twelve (12) months. Document review on 09/23/2025 starting at 2:00 PM revealed that one of the two (2) inspections of the kitchen hood extinguishing system had been completed in the past twelve (12) months. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator and facility maintenance manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.2.5.1, 9.2.3 2011 NFPA 96, Sections: 11.4, 11.5; Table 11.4	K0324		12/10/2025
K0345 SS = D Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and	K0345	Contractor will perform an semi-annual inspection of the acid batteries, instead of annually. Contractor completed an inspection of the building and performed the battery test. Moving forward the semi-annual battery acid test and annual fire protection test will be available at time of survey.	12/10/2025

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K0345 SS = D Bldg. 01	Continued from page 12 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 evidence of maintenance for 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 could affect the entire fire alarm system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 09/23/2025 starting at 2:00 PM revealed the facility failed to provide documentation of testing and maintenance of the fire alarm system at the main building (NH) in accordance with 2010 NFPA 72. The facility failed to provide documentation of the following tests: a) Monthly Activation – 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) Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and facility maintenance manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.6.3.1, 9.6.1.5 2010 NFPA 72, Tables 14.3.1, 14.4.5	K0345		12/10/2025
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K0355	Training completed with maintenance crew on every location of fire extinguishers, work will be checked weekly.	12/10/2025

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K0355 SS = D Bldg. 01	Continued from page 13 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: Observation on 09/23/2025 at 12:05 PM revealed the portable fire extinguisher in the boiler room was missing records of monthly inspections. Further observations revealed additional portable fire extinguisher at the generator was also missing records of monthly inspections. Interview with the facility maintenance manager and the facility administrator at the time of the observations acknowledged the deficiencies. Interview with the facility maintenance manager 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	K0355		12/10/2025
K0781 SS = D Bldg. 01	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observations and staff interview, the facility failed to ensure portable space heaters used in nonsleeping staff and employee areas were provided with heating elements that would not exceed 212 degrees Fahrenheit (100 degrees Celsius) in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure portable space heaters are provided with the required high temperature safety limits for their heating elements could increase the	K0781	Maintenance staff performed a heating element test on the portable space heater on the Community Relations Directors office, in the findings it did not exceed the 212 degrees Fahrenheit. Moving forward all portable space heater will be removed from offices.	12/10/2025

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K0781 SS = D Bldg. 01	Continued from page 14 risk of fire leading to injury or death. The findings affected all staff in the reception office. The findings were: Observations on 09/23/2025 at 9:31 AM revealed a portable space heater inside the community relations office. Further observation and staff interview revealed the portable space heaters did not include manufacturer's documentation that the heating element would not exceed 212 degrees Fahrenheit (100 degrees Celsius) in accordance with the 2012 NFPA 101, Life Safety Code. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.7.8	K0781		12/10/2025
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 and staff interview, the facility failed to provide power strips in accordance with	K0920	Removed the daisy chained power cords all together, trained office on proper use of power strips.	12/10/2025

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K0920 SS = D Bldg. 01	Continued from page 15 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 09/23/2025 at 9:26 AM in accounts office revealed multiple power cords daisy-chained together. All power strips shall be used with general caution. 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. Power strips used in non-patient care areas shall be UL rated. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, 10.2.3.6, 10.2.4	K0920		12/10/2025

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 09/23/2025 and 09/24/2025. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		12/10/2025
E0031 SS = F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	E0031	Contact information for the Long Term Care Ombudsman updated and included in the emergency contact information.	12/10/2025

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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E0031 SS = F	Continued from page 1 *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with a communication plan in accordance with §483.73(c)(2). Failure to provide a communication plan with the required contact information could delay response in the event of an emergency leading to injury or death. The deficiency could affect all residents, staff, and visitors in the case of an emergency. The findings were: Review of the facility EPP on 09/23/2025 starting at 4:30 PM revealed that the facility had included a communication plan, but failed to provide the required contact information for LTC Ombudsman. Interview with the facility maintenance manager and the facility administrator, along with document review at the time of observation, acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0031		12/10/2025
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	E0041	Maintenance staff performed a 4 hours generator test with transfer switch engaged, moving forward this will be tested every 36 months and documented. Maintenance performed a lead battery gravity test, moving forward this will be tested on a monthly basis and documented,	12/12/2025

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E0041 SS = F	Continued from page 2 facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 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.	E0041		12/12/2025

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E0041 SS = F	Continued from page 3 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. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to 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, 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 09/23/2025 starting at 2:00 PM	E0041		12/12/2025

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E0041 SS = F	Continued from page 4 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 in lieu of the testing of specific gravity when applicable or warranted in accordance with 2010 NFPA 110, section 8.3.7.1. 2. 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 and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0041		12/12/2025