STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/23/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laramie Health and Rehabilitation	**503 S 18th St , Laramie, Wyoming, 82070**

(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 Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 7/23/26 following a Wyoming Healthcare Licensing and Surveys, Life Safety Code Survey on 6/02/26. At this Comparative Federal Monitoring Survey, Laramie Health and Rehabilitation was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90(a), Life Safety from Fire and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. Laramie Health and Rehabilitation is a two-story building of Type V (000) construction built in 1920, 1972, and 1993. The building is fully sprinklered and there is supervised smoke detection in the corridors and spaces open to the corridors. The building is supplied with emergency power by a 45-kW natural gas emergency generator. Laramie Health and Rehabilitation has a total of 105 dually certified beds. At the time of the survey, the census was 57. The requirement at 42 CFR, Subpart 483.90(a) was NOT MET as evidenced by:	K0000		
K0345 SS = F 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 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:	K0345		08/24/2026

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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K0345 SS = F Bldg. 01	Continued from page 1 Based on record review and staff interview, the facility failed to properly maintain the fire alarm system in accordance with NFPA 101 - 2012 edition, Sections 19.3.4.1, 9.6.1.3 and NFPA 72 - 2010 editions, Sections 14.3.1, 14.4.5 and 14.4.5.3.2. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include: On 7/23/26 at 10:06am, review of fire alarm annual report dated May 2026 revealed that the annual report did not contain the sensitivity range for the testing of detectors. Interview with the Maintenance Director confirmed the report did not contain the ranges for each detector. This finding was confirmed by the Maintenance Director at the time of review and the Administrator and Maintenance Director at the exit conference.	K0345		08/24/2026
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 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review, observation and interview,	K0353		08/24/2026

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K0353 SS = F Bldg. 01	Continued from page 2 the facility failed to maintain the sprinkler system in accordance with NFPA 101 - 2012 edition, Sections 19.3.5.3, 9.7.5, NFPA 13 – 2010 edition, Section 8.5.6, NFPA 25 - 2011 edition, Sections 5.1, 5.2, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.3, 5.3.4 and 13.4.4.2.9. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include: 1. On 7/23/26 at 9:30am, record review revealed for the dry sprinkler system report dated May 2026 a deficiency that the three-year air leakage test was due. Interview with the Maintenance Director confirmed that the leakage test had not been completed. 2. On 7/23/26 at 11:50am, observation revealed a tag that indicated anti-freeze system in the basement. Record review of the wet sprinkler system indicates an anti-freeze control valve, but under the question “Are there anti-freeze systems at this location?” the inspector selected “N/A”. Interview with the Maintenance Director revealed he believes the facility has an anti-freeze system but does not have documentation for anti-freeze solution testing or the type of solution. 3. On 7/23/26 at 1:30pm, observation revealed wires hung on sprinkler piping in the attic above the server room. 4. On 7/23/26 at 2:15pm, observation revealed debris on the sprinkler in Room 338 and in the Laundry dryer room. 5. On 7/23/26 at 2:48pm, observation in Room 117 revealed a blanket stored in the resident closet within 14 inches of the sprinkler deflector. These findings were confirmed by the Maintenance Director at the time of observation and the Administrator, and Maintenance Director at the exit conference.	K0353		08/24/2026
K0355 SS = F 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	K0355		08/24/2026

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K0355 SS = F Bldg. 01	Continued from page 3 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 record review and staff interview, the facility failed to maintain fire extinguishers in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10 - 2010 edition Sections 7.2, 7.3.1, 7.3.3. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include: On 7/23/26 at 9:46am, record review of the May 2026 annual fire extinguisher report revealed that five extinguishers failed the inspection and require service. Interview with the Maintenance Director revealed the facility is in process of soliciting bids to replace the extinguishers. This finding was confirmed by the Maintenance Director at the time of observation and the Administrator, and Maintenance Director at the exit conference.	K0355		08/24/2026
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. 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)	K0761		08/24/2026

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K0761 SS = F Bldg. 01	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and staff interview, the facility did not maintain all fire rated doors in accordance with the requirements of NFPA 101 - 2012 edition, Sections 18.7.6 and 8.3.3.1 and NFPA 80 - 2010 edition, Section 5.2. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include: 1. On 7/23/26 at 9:17am, review of the life safety documentation revealed the facility did not complete annual fire door inspections. Interview with the Maintenance Director confirmed the facility completes corridor and smoke barrier door "latch and gap" inspections, but does not complete an inspection for fire rated doors that meets NFPA 80 requirements. 2. On 7/23/26 at 1:40pm, observation revealed a 90-minute fire rated door to the generator room. 3. On 7/23/26 at 2:10pm, observation revealed a 90-minute fire rated door near Room 241 that did not latch when tested three of three times. These findings were confirmed by the Maintenance Director at the time of observation and reviewed with the Administrator and Maintenance Director at the exit conference.	K0761		08/24/2026
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 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	K0918		01/23/2027

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K0918 SS = F Bldg. 01	Continued from page 5 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 record review and staff interview, the facility did not maintain the emergency electrical system in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1, 9.1, 9.1 and NFPA 110 - 2010 edition, Section 8.4.9. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include: On 7/23/26 at 10:15am, review of the life safety documentation revealed that a 36-month four-hour load test has not been completed for the natural gas emergency generator. A document titled “Generator Load Test” was provided which stated “We have never been able to have a proper load test on our generator. We have been told by the company for many years that they can’t get their machine close enough to the generator to do the test”. Interview with the Maintenance Director confirmed that no four-hour load test has been completed due to the vendor company’s inability to locate their equipment close enough to the generator in the middle of the facility. This finding was confirmed by the Maintenance Director at the time of review and reviewed with the Administrator and Maintenance Director at the exit conference.	K0918		01/23/2027

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K0271 SS = E 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 properly maintain the exit discharge in accordance with NFPA 101 - 2012 edition, Sections 19.2.7, 7.1.7 and 7.7. This deficient practice could affect approximately 15 of 57 residents and two of ten smoke compartments. Findings include: On 7/23/26 at 2:30pm, observation outside the exit door by the Therapy Room and Room 50 revealed a nine-inch height difference in the exit discharge. The exits lead to a paved pathway of uneven nature through a fence to the public way with a 9-inch tall curb. Interview with the Maintenance Director confirmed the egress pathway would be utilized by residents during an emergency. This could delay egress of residents that may be evacuated using a wheelchair or could be a trip hazard during egress. This finding was confirmed by the Maintenance Director at the time of observation and reviewed with the Administrator and Maintenance Director at the exit conference.	K0271		01/23/2027
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke	K0372		08/24/2026

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K0372 SS = E Bldg. 01	Continued from page 7 dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2, 8.5.2.1, 8.5.2.2, 8.5.2.3 and 8.5.6. This deficient practice could affect approximately 14 of 57 residents, and one of ten smoke compartments. Findings include: 1. On 7/23/26 at 1:30pm, observation at the smoke barrier in the attic above the server room revealed two one-inch conduit penetrations without fire stopping. 2. On 7/23/26 at 1:35pm, observation in the boiler/generator room revealed a half-inch gap around the venting of the boiler into the attic space. Interview with the Maintenance Director revealed the boiler was recently upgraded and the gap was most likely from the replacement. 3. On 7/23/26 at 2:18pm, observation revealed in the Lab an approximate eight-inch hole in the ceiling. Interview with the Maintenance Director revealed that an air conditioner unit was recently removed from the room and left behind the hole in the ceiling. These findings were confirmed by the Maintenance Director at the time of observation and the Administrator and Maintenance Director at the exit conference.	K0372		08/24/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K0363		08/24/2026

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K0363 SS = D Bldg. 01	Continued from page 8 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that resist the passage of smoke in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.6.3.1, 19.3.6.3.4, and 19.3.6.3.5. This deficient practice could affect an isolated number of residents, staff, and visitors, and one of ten smoke compartments. Findings include: On 7/23/26 at 2:01pm, observation revealed the clean utility corridor door near Room 342 had a half-inch penetration above the handle.	K0363		08/24/2026

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K0363 SS = D Bldg. 01	Continued from page 9 This finding was confirmed by the Maintenance Director at the time of observation and reviewed with the Administrator and Maintenance Director at the exit conference.	K0363		08/24/2026
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 and staff interview, the facility failed to use electrical power strips and extension cords in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.5, 19.5.1, NFPA 99 - 2012 edition, Sections 10.2.3.6,10.2.4 and NFPA 70 - 2011 edition, Sections 400.7 and 400.8. This deficient practice could affect an isolated number of residents, staff, and visitors and one of ten smoke compartments. Findings include: On 7/23/26 at 2:40pm, observation revealed in the Therapy office a power strip plugged into another power strip. Interview with the Maintenance Director confirmed that staff are not authorized to daisy chain devices.	K0920		08/24/2026

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K0920 SS = D Bldg. 01	Continued from page 10 This finding was confirmed by the Maintenance Director at the time of observation and the Administrator and Maintenance Director at the exit conference.	K0920		08/24/2026
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		08/24/2026

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K0923 SS = D Bldg. 01	Continued from page 11 Based on observation and interview, the facility failed to store oxygen cylinders in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.3.2.4, 8.7 and NFPA 99 - 2012 edition, Sections 11.3.2., and 11.3.2.3, This deficient practice could affect an isolated number of residents, staff, and visitors, and one of ten smoke compartments. Findings include: 1. On 7/23/26 at 2:20pm, observation at the oxygen storage/transfilling area revealed a wooden pallet stored near 10 60-liter reservoirs. Interview with the Maintenance Director revealed the wooden pallet is utilized as a stand for the personal oxygen containers. 2. On 7/23/26 at 2:25pm, observation revealed the door had signs of “Oxygen Supply – No Smoking” and “Warning: Oxygen Transfer Occurring” but did not contain the verbiage “CAUTION: OXIZIDING GAS(ES) STORED WITHIN – NO SMOKING”. These findings were confirmed by the Maintenance Director at the time of observation and reviewed with the Administrator and Maintenance Director at the exit conference.	K0923		08/24/2026
K0521 SS = C Bldg. 01	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 record review and staff interview, the facility did not inspect fusible link fire dampers in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.5.2.1 and 9.2.1, and NFPA 80 - 2010 edition, Section 19.4.9, and 19.5. This deficient practice could affect all 57 residents and ten of ten smoke compartments. Findings include:	K0521		08/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/23/2026**

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K0521 SS = C Bldg. 01	Continued from page 12 On 7/23/26 at 10:21am, review of the fusible link fire damper inspection report (dated 8/22) revealed the there was no documented information for the location of the dampers inspected, name of inspector, and deficiencies discovered. Interview with the Maintenance Director revealed the facility had only received the cover sheet that indicates 12 fusible links were replaced and the dining room fusible links were determined not be broken. This finding was confirmed by the Maintenance Director at the time of review and the Administrator and Maintenance Director at the exit conference.	K0521		08/24/2026

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E0000	Initial Comments An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 7/23/26 following a Wyoming Healthcare Licensing and Surveys, Life Safety Code Survey on 6/02/26. At this Comparative Federal Monitoring Survey, Laramie Health and Rehabilitation was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73 - Emergency Preparedness. Laramie Health and Rehabilitation has a total of 105 dually certified beds. At the time of the survey, the census was 57. The requirement at 42 CFR, Subpart 483.73 was NOT MET as evidenced by:	E0000		
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	E0039		08/24/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

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E0039 SS = F	Continued from page 1 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 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.	E0039		08/24/2026

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E0039 SS = F	Continued from page 2 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that 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.	E0039		08/24/2026

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E0039 SS = F	Continued from page 3 (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (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:	E0039		08/24/2026

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E0039 SS = F	Continued from page 4 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[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	E0039		08/24/2026

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E0039 SS = F	Continued from page 5 natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises 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	E0039		08/24/2026

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E0039 SS = F	Continued from page 6 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not 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.	E0039		08/24/2026

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E0039 SS = F	Continued from page 7 (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility did not document two exercises to test the emergency plan at least annually in accordance with the requirements of 42 CFR 483.73(d)(2). This deficient practice could affect all 57 residents.	E0039		08/24/2026

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E0039 SS = F	Continued from page 8 Findings include: On 7/23/26 at 12:52pm, record review of the "Emergency Disaster Plan" (dated 4/26) revealed the facility had conducted one facility wide exercise but did not adequately document participation in the June 2026 exercise including an after-action report. Interview with the Maintenance Director confirmed the facility has not completed a community based exercise within the last 12 months. This finding was confirmed by the Maintenance Director at the time of review and reviewed with the Administrator and Maintenance Director at the exit conference.	E0039		08/24/2026