STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING **01** B. WING _____	**04/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK	**1445 UINTA DRIVE** **GREEN RIVER, WY 82935**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/01/2025. The following demonstrates noncompliance in accordance with 42 CFR 483.73.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039		5/23/25

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

Electronically Signed | 04/25/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 039	Continued From page 1 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. (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	E 039		

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E 039	Continued From page 2 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	E 039		

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E 039	Continued From page 3 messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation 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	E 039		

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E 039	Continued From page 4 questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based 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	E 039		

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E 039	Continued From page 5 designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 6 exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises	E 039		

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E 039	Continued From page 7 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. (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	E 039		

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E 039	Continued From page 8 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 document review and staff interview, the facility failed to conduct exercises to test the emergency plan as required by 483.73(d). Failure	E 039	E039 EP Testing Requirements The facility failed to conduct exercises to	

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E 039	Continued From page 9 to test the emergency plan as required could result in a lack of staff and resident knowledge of the plan and procedures, which may result in injury or death during an emergency. The deficiency could impact all staff, residents, and visitors. The findings were: Document review on 04/01/2025 starting at 8:30 AM revealed that no records were available to demonstrate that the facility had conducted exercises to test the emergency plan at least twice in the past year. Facility staff indicated that exercises are scheduled to be performed in the near future, and confirmed that no exercise had been performed in the past twelve (12) months. Interview with the facility administrator and facility maintenance manager at the time of the 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 confirmed the deficiency.	E 039	test the emergency plan annually. Two separate exercises have already been completed since the date of survey. Maintenance Director and ALF supervisor participated in a mass chemical spill training/table top that was put on by Sweetwater County on April 16, 2025. The Sweetwater County Sherriff's office came on 4/22/25 and provided a training and drill to staff on an active shooter. Maintenance Director was provided education on the requirements for EP Testing. A new section was added to Emergency Preparedness binder to document testing/trainings. Administrator will ensure at least 2 tests per year are completed.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 04/01/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1987.	K 000		

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K 000	Continued From page 10 The building was equipped with a supervised automatic dry sprinkler system, automatic wet sprinkler system with an anti-freeze loop, and an addressable fire alarm system. The facility had a capacity of 59 certified Medicare and Medicaid beds with a census of 42. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on Document review and staff interview, the facility failed to test battery-powered emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test battery-powered emergency lighting as required could result in failure of the equipment during an emergency, which could result in injury or death. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 04/01/2025 starting at 8:30 AM revealed the facility had not been testing battery-powered emergency lighting systems as required. Battery-powered emergency lighting systems must be tested for thirty (30) minutes each month, and ninety (90) minutes annually. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement.	K 291	K291 Emergency Lighting The Facility failed to test battery-powered emergency lighting in accordance with the 2012 NFPA 101 life safety code. All "EXIT" signs have been replaced and now have a push button on the bottom that allows for testing. Each sign has been numbered, and there is a tracking system in place. Maintenance Director was provided education on emergency light testing. 30 minute monthly checks will be added to the mandatory monthly checks in the life safety binder. A yearly 90 minute test will also be added to the life safety binder. Administrator to do monthly audits for 4 months to ensure these tests are happening, and that it becomes a routine	5/23/25

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K 291	Continued From page 11 Interview with the facility administrator and facility maintenance manager at the time of exit confirmed the deficiency. REF: NFPA 101, Section 19.2.9.1 and 7.9	K 291	test.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking equipment in	K 324	K324 Cooking Facilities	5/23/25

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K 324	Continued From page 12 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 properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were: Observation on 04/01/2025 at 10:30 AM in the kitchen revealed a deep fryer located adjacent to the griddle, which are both located on top of a wheeled drawer cabinet. Further observation revealed that the deep fryer was not provided with nozzle protection for the ansul system. Additionally, it was observed that no means were provided to ensure that the wheeled cabinet and cooking appliances were returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator and facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Chapter 10 and Section 12.1.2.3	K 324	Facility failed to protect cooking equipment 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. In the kitchen there was a deep fryer, adjacent to the griddle on top of a wheeled drawer cabinet. The fryer was not provided with the nozzle protection for the ansul system. There were also no means provided to ensure that the wheeled cabinet and cooking appliances were returned to the approved location beneath the fire suppression system after being moved for service or cleaning. The deep fryer was immediately removed from the kitchen and is no longer in use. Maintenance Director marked the floor with tape to show exactly where the appliances are supposed to be, and ensures that they get put back in the appropriate location after moving for cleaning or servicing. Maintenance Director and kitchen personnel were provided education. Quarterly audits will be completed to ensure compliance. Audit findings will be discussed in QA meetings.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		5/23/25

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	535033	A. BUILDING **01** B. WING _____	**04/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK	**1445 UINTA DRIVE** **GREEN RIVER, WY 82935**

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K 511	Continued From page 13 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to maintain gas-fired equipment could lead to system damage and failure, resulting in injuries to staff. The deficiency affected the kitchen, and all staff working within. The findings were: Observation on 04/01/2025 at 10:30 AM in the kitchen revealed a gas-fired griddle and deep fryer located on top of a drawer cabinet that was on casters.. Further observation revealed that the cooking equipment was not provided with the required restraint to protect the flexible gas piping when the cooktop is moved for service or cleaning. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that they were not aware of the requirement.	K 511	K511 Utilities-Gas and Electric The facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. In the kitchen, there was a gas-fired griddle and deep fryer located on top of a drawer cabinet that has casters on the bottom. The cooking equipment was not provided with the required restraint to protect the flexible gas piping from damage when the cooktop is moved for service or cleaning. The deep fryer was completely removed and is no longer in use. Maintenance Director anchored the drawer cabinet to the wall with a chain on both sides of it so that it can only be pulled out a minimal distance for cleaning and servicing. Education was provided to the Maintenance Director and kitchen	

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K 511	Continued From page 14 Interview with the facility administrator and facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 54, Section 9.6.1.2	K 511	personnel.	
K 902 SS=D	Gas and Vacuum Piped Systems - Other CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders in accordance with the requirements of 2012 NFPA 99, Health Care Facilities Code. Failure to store oxygen cylinders as required could result in injury or death during an emergency. The deficiency could impact residents, staff, or visitors within the vicinity of the storage location. The findings were: Observation on 04/01/2025 at 10:15 AM in the oxygen cylinder storage room revealed one-hundred and fifty-six (156) oxygen cylinders, with a capacity of twenty-five (25) cubic feet each, for a total of three-thousand and nine-hundred (3,900) cubic feet in storage. It was observed that the space was provided with a ninety (90) minute fire-rated door, and the space was of 1-hour rated construction, but that ventilation was not provided	K 902	K 902 Utilities-Gas and Vacuum Piped Systems- Other The facility failed to store oxygen cylinders in accordance with the requirements of 2012 NFPA 99, Health Care Facilities Code. Failure to store oxygen cylinders as required could result in injury or death during an emergency. The facility had too many oxygen tanks in the oxygen storage room per cubic feet and per the room fire rating. The storage room had 156 oxygen cylinders, but has a max capacity of 120 cylinders. Oxygen cylinders were removed from the room and stored in other parts of the	5/23/25

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K 902	Continued From page 15 in accordance with NFPA 99. Interview with the facility administrator and facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator and facility maintenance manager at the time of exit confirmed the deficiency. REF: NFPA 99, Section 9.3.7 and 9.3.7.5.3	K 902	building to get us back into compliance. Our oxygen vendor was contacted and asked to bring less oxygen tanks at a time to make sure the storage room doesn't get too full. A warning paper was attached to the oxygen storage room door notifying everyone that the maximum number of tanks allowed to be in there at a time is 120. Administrator and Maintenance Director were educated real time by the Life Safety Surveyor. All staff will be educated on this in our next in-service which is May 21, 2025. Weekly audits will be done for 3 months by either the Administrator or Maintenance Director to ensure continual compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		5/23/25

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K 918	Continued From page 16 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to perform annual testing and maintenance of main and feeder circuit breakers in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to routinely test and maintain main and feeder circuit breakers could allow mechanical failures to go undetected, leading to power loss within the facility, which could result in injury or death. The deficiency could impact all residents, staff, and visitors within the facility. The findings were: Document review on 04/01/2025 starting at 8:30 AM revealed that the facility could not demonstrate annual testing of main and feeder circuit breakers, and no evidence was provided to demonstrate that a program for periodically exercising the components had been established in accordance with manufacturer	K 918	K918 Electrical Systems- Essential Electric System (LSC 2012 Health Existing) The facility failed to perform annual testing and maintenance of main and feeder circuit breakers in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to routinely test and maintain main and feeder circuit breakers could allow mechanical failures to go undetected, leading to power loss within the facility, which could result in injury or death. No testing was done on the main and feeder circuit breakers that are directly tied to the generator providing emergency services. The administrator reached out to	

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K 918	Continued From page 17 recommendations. Interview with the facility administrator and facility maintenance manager at the time of the 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 confirmed the deficiency. REF: NFPA 99, Section 6.4.4.1.2	K 918	the Life Safety Surveyor for guidance on how to best correct this deficiency. The Life Safety Surveyor provided the contact information of the Maintenance Supervisor in a different part of Wyoming. Administrator was educated by the Maintenance Supervisor and referred to a professional electrician who specializes in this kind of testing. The professional electrician is scheduled to come to the facility on May 12, 2025 to perform all required testing. This testing consists of checking: voltage, amperage, temperature, and trip test to each individual breaker. Each breaker will be visually and mechanically inspected for defects and operation. Each breaker will be cleaned and re-installed using di-electric grease. All findings will be documented, and an updated panel schedule will be left on each panel. All lugs will be tightened to ensure proper connection. Panels will be identified and labeled. Education on electrical testing requirements were provided to Maintenance Director. Administrator will work with electrician to form a plan for routine maintenance as well as ensure that this testing is done annually.	