STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
E0000	Initial Comments An Emergency Prepared survey was performed by Healthcare Licensing and Surveys on 07/09/2025. The following deficiencies indicate noncompliance with 42 CFR 483.73.	E0000		07/25/2025
E0006 SS = F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E0006	The facility will revise the emergency preparedness plan to ensure alignment with the considerations in the Lincoln County Emergency Operations Plan (LCEOP). This plan is available to view at www.lincolncountywy.gov. The facility will ensure the EPP reflects weather, infectious diseases, and cybersecurity threats as part of its all-hazards approach.	08/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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E0006 SS = F	Continued from page 1 identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to perform a risk assessment utilizing an all-hazards approach when developing their Emergency Preparedness Plan (EPP). Failure to perform a risk assessment utilizing an all-hazards approach could result in inadequate or incomplete policies and procedures for emergencies, resulting in injury or death in the event of an emergency. The deficiency could impact all residents and staff in the facility. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not performed an all-hazards risk assessment when developing the plan. Interview with the facility maintenance and administrative staff indicated that a risk assessment plan had been performed in the past, but it could not	E0006		

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E0006 SS = F	Continued from page 2 be located at the time of the survey. Further interview could not establish that the facility utilized an all-hazards approach when determine risk factors that could affect the facility, such as weather, infectious diseases, or cyber security threats. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0006		
E0013 SS = F	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of	E0013	SLHD Safety Committee will review and document changes annually. The committee will review any changes in the LCEOP and discuss potential changes needed to the EPP. Paper confirmation of the EPP review will be physically distributed to all EPP binders by the Safety Committee Secretary. In addition, the facility will utilize its electronic policy and procedure review and repository vendor to ensure evidence of the EPP being reviewed and updated annually.	08/15/2025

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E0013 SS = F	Continued from page 3 the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to document that their Emergency Preparedness Plan (EPP) policies and procedures were reviewed and updated at least annually. Failure to update the EPP as required could result in out-of-date information regarding contacts or procedures, which may result in injury or death in the event of an emergency. The deficiency could impact all staff and residents in the facility. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility failed to document that the Emergency Preparedness Plan (EPP) policies and procedures were reviewed and updated at least annually. Interview with the facility maintenance and administrative staff along with document review indicated the EPP policies and procedures, including the risk assessment, and communication plan, were not reviewed and updated at least annually. Interview with the maintenance and administrative staff indicated that the (EPP) policies and procedures had been updated but they could not be located at the time of the interview. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0013		
E0015 SS = F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E0015	Revise EPP to reflect the policies and procedures with regard to subsistence planning, emergency power plans, HVAC management and sewage and waste disposal.	08/15/2025

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E0015 SS = F	Continued from page 4 §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.	E0015		

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E0015 SS = F	Continued from page 5 (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with policies and procedures that align with the facility risk assessment and communication plan, addressing the subsistence needs for residents and staff. Failure to include subsistence needs for the duration of the emergency or until the facility is evacuated, could result in injury or death in the event of an emergency. The deficiency could impact all residents and staff in the facility. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed the subsistence needs of residents and staff when developing the plan. Interview with the facility maintenance and administrative staff along with document review indicated the EPP did not establish adequate provisions for subsistence needs for all residents and staff in the event of an emergency. The EPP did not address fuel supply for alternate source of power required to maintain temperatures, emergency lighting, fire detection and alarm systems. The EPP did not address how heating and cooling of the facility would be maintained during loss of primary power source in order to ensure safe temperatures are maintained in those areas deemed necessary to protect patients during the course of an emergency as determined by the facility risk assessment. The EPP did not include policies and procedures for sewage and waste disposal. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0015		
E0020 SS = F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3),	E0020	The Facility will improve the EPP and address the need to provide care and treatment and evacuate residents, staff members and families. These changes will reflect plans to update the plan annually, provide alternate means of communication, specify staff responsibilities, and illustrate agreements with evacuation sites. Review	08/15/2025

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E0020 SS = F	Continued from page 6 §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.	E0020	Continued from page 6 of this plan will occur annually.	

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E0020 SS = F	Continued from page 7 * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with policies and procedures, that align with the facility risk assessment and communication plan, addressing safe evacuation from the facility. Failure to include procedures for safe evacuation in the event of an emergency could result in injury or death. The deficiency could impact any resident, staff, or visitor that needs to be evacuated in an emergency. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed safe evacuation from the facility with their policies and procedures when developing the plan. Interview with the facility maintenance and administrative staff along with document review indicated the EPP policies and procedures for evacuation did not include the care and treatment needs of the resident population, evacuation of family and staff members, staff responsibilities during evacuation, agreements with identified evacuation sites, agreements for transportation, and alternate means of communication with staff and local agencies when developing the plan. The EPP, including procedures for safe evacuation, were not updated at least annually. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0020		
E0022 SS = F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies	E0022	The facility will add detailed policies and procedures within the plan for “Emergency Sheltering and Supplies” to the Emergency Preparedness Plan. These changes will include calculation of potential staff and volunteers sheltering to accommodate the need for water, food, and supplies. Also, details regarding securing the facility, communication with residents and families, status updates and planning for potential evacuation will be developed.	08/15/2025

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E0022 SS = F	Continued from page 8 and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with policies and procedures for sheltering in place. Failure to provide policies and procedures for sheltering in place could result in inadequate staff response and inadequate supplies for an emergency requiring sheltering in place, resulting in injury or death. The deficiency could impact all residents, staff, and visitors. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed sheltering in place with their policies and procedures when developing the plan. Interview with the facility maintenance and administrative staff along with document review indicated the EPP policies and procedures did not address sheltering in place when developing the plan. The EPP did not include policies and procedures for sheltering in place including staff and volunteers who remain at the facility. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0022		
E0035 SS = F	LTC and ICF/IID Sharing Plan with Patients	E0035	The facility will develop policies and procedures,and	08/15/2025

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E0035 SS = F	Continued from page 9 CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an Emergency Preparedness Plan (EPP) with policies and procedures addressing resident family notifications. Failure to provide policies and procedures for notifying resident families could result in families being inadequately informed on the status of the facility and residents. The deficiency could impact all residents and resident family members. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed resident family notifications with their policies and procedures when developing the plan. Interview with the facility maintenance and administrative staff along with document review indicated the EPP policies and procedures did not address a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives.	E0035	Continued from page 9 update the EPP to provide an effective method for sharing information from the EPP with residents and family.	

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E0035 SS = F	Continued from page 10 Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0035		
E0036 SS = F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).	E0036	In order to ensure all staff are properly trained on the EPP, the facility will develop a training and testing plan by August 15, 2025. The training plan will reflect risks identified in the facility risk assessment, account for documenting, reviewing, and updating the EPP as well as a process for evaluating the effectiveness of the training.	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

(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
E0036 SS = F	Continued from page 11 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of an emergency preparedness training and testing program based on the facility risk assessment. Failure to provide an EPP training and testing program could result in inadequate or harmful actions from staff in the event of an emergency, resulting in injury or death. The deficiency could impact all residents, staff, and visitors. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed an emergency preparedness training and testing program with their policies and procedures when developing the plan. Interview with the facility maintenance and administrative staff along with document review indicated the facility failed to provide and emergency preparedness training and testing program reflecting the risks identified in the facility risk assessment that is documented, reviewed and updated at least annually. The facility failed to provide documentation of training and education for staff, contractors and facility volunteers ensuring awareness of the emergency preparedness program. The facility failed to provide documentation of a testing program for evaluating the effectiveness of the training to identify gaps and areas of improvement. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0036		
E0037 SS = F	EP Training Program	E0037	The facility will develop policies and procedures to ensure all new and existing staff, volunteers, and	08/15/2025

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E0037 SS = F	Continued from page 12 CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including	E0037	Continued from page 12 individuals providing services under agreement, are properly trained on the EPP.	

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E0037 SS = F	Continued from page 13 nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.	E0037		

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E0037 SS = F	Continued from page 14 (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The	E0037		

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E0037 SS = F	Continued from page 15 CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide an emergency preparedness training program based on the facility risk assessment and communication plan. Failure to provide an emergency preparedness training program could result in inadequate or harmful actions from staff in the event of an emergency, resulting in injury or death. The deficiency could impact all residents, staff, and visitors. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not addressed an emergency preparedness training program with their policies and procedures when developing the plan. Interview with the facility maintenance and	E0037		

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E0037 SS = F	Continued from page 16 administrative staff along with document review revealed the facility failed to provide documentation of initial and annual EPP training reflective of the facility risk assessment for all new and existing staff, individuals providing services under arrangement, and volunteers. The facility failed to maintain documentation of the training. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0037		
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E0039	The facility will develop a plan to test and document exercises twice per year. Planning will include a designated full-scale facility-based exercise and either another full-scale exercise, mock disaster drill, or a tabletop exercise. The plan will also include analysis of the response, documentation of the drill, and potential revision of the EPP based on the efficacy of the response.	08/15/2025

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E0039 SS = F	Continued from page 17 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 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	E0039		

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E0039 SS = F	Continued from page 18 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. (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	E0039		

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E0039 SS = F	Continued from page 19 (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: (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.	E0039		

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E0039 SS = F	Continued from page 20 (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 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	E0039		

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E0039 SS = F	Continued from page 21 (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 (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	E0039		

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E0039 SS = F	Continued from page 22 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. (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	E0039		

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E0039 SS = F	Continued from page 23 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of testing of the facility emergency preparedness plan. Failure to provide testing of the emergency preparedness plan could result in inadequate or harmful actions from staff in the event of an emergency, resulting in injury or death. The deficiency could impact all residents, staff and visitors. The findings were: Review of the EPP on 07/09/2025 starting at 10:30 AM revealed that the facility had not provided documentation of testing of the facility emergency preparedness program at least twice annually. Interview with the facility maintenance and administrative staff along with document review revealed the facility failed to provide documentation	E0039		

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E0039 SS = F	Continued from page 24 of exercises to test the EPP at least twice per year using the EPP procedures including the following: 1. Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, conduct an individual, facility-based exercise. 2. Conduct an additional annual exercise that may include but is not limited to the following: a. Second full-scale exercise that is community based or individual facility based functional exercise b. Mock disaster drill c. Tabletop exercise or workshop that is led by a facilitator The facility had run multiple tabletop exercises, but failed to perform a full scale exercise within the last (12) twelve months. The facility failed to 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. Interview with the maintenance staff and administrative staff at the time of exit confirmed the deficiency.	E0039		
K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 07/09/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90, except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single-story building with a basement of Type II (111) construction built in 1998. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and an addressable fire alarm. The facility had a capacity of 24 certified Medicaid beds with a census of 18 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		07/25/2025
K0231 SS = D	Means of Egress Capacity CFR(s): NFPA 101 Means of Egress Capacity	K0231	The maintenance department will move the water heater to ensure the egress is at least twenty-eight inches in width.	09/09/2025

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K0231 SS = D	Continued from page 25 The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain a means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain a means of egress as required could result in impediments to egress during an emergency, which could result in injury or death. The deficiency impacted one (1) of multiple access points to an exit and could potentially impact any residents, staff, and visitors in the area. The findings were: Observation on 07/09/2025 at 9:10 AM in the boiler room revealed that the second exit at the north end of the room was obstructed to a width of twenty-one (21) inches between equipment locations. Access to an exit must be maintained at a minimum width of twenty-eight (28) inches. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.3.1 and 7.3.4.1.2	K0231		
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test battery-operated emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test battery-operated emergency lighting as required could result in failure to identify exits during an emergency, which could result in injury or death. The deficiency impacted all exit	K0291	Batteries and fixtures have been tested, and nonfunctional units replaced. The preventive maintenance schedule has been updated to include monthly testing for 30 seconds each and annually for 90 minutes as stated in the 2012 NFPA 101.	09/09/2025

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K0291 SS = F	Continued from page 26 signage throughout the facility and could potentially impact all residents, staff and visitors. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed no documentation was available to demonstrate testing of the battery-operated exit lighting. Battery-operated emergency lighting shall be tested monthly for sixty (60) seconds and annually for ninety (90) minutes. Interview with the facility maintenance manager indicated they were unaware of means for testing the exit lighting, so they were replacing the batteries on an annual basis. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 7.9.3.1.1 (1) and 7.9.3.1.2 (5).	K0291		
K0324 SS = E	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	K0324	The maintenance department will install an approved eight-inch baffle between the fryer and the adjacent cook top. Maintenance will install an approved wheel stop on the floor to ensure the fryer is returned to an approved location after being moved.	09/09/2025

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K0324 SS = E	Continued from page 27 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to protect cooking facilities could lead to fire resulting in injury or death. The deficiency impacted one (1) of multiple cooking appliances and could potentially impact any staff or visitors in the cooking facility. The findings were: Observation on 07/09/2025 at 10:12 AM in the cooking facility revealed that the facility failed to provide adequate separation between the deep fryer and the surface flames of the adjacent cooking appliance, or an eight (8) inch baffle installed between the deep fryer and the surface flames of the adjacent appliance. The deep fryer was not provided with an approved method to ensure the appliance is returned to an approved design location. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.5.1, 9.2.3, and 2011 NFPA 96, Sections 12.1.4 and 12.1.5	K0324		
K0325 SS = D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room	K0325	The plant operations director will create a policy and procedures for training all current and future maintenance staff on the proper placement of ABHR dispensers. All ABHR dispensers have been relocated or removed where the installation did not comply with spacing.	09/09/2025

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K0325 SS = D	Continued from page 28 * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect alcohol-based hand rub dispensers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect alcohol-based hand rub dispensers could lead to fire resulting in injury or death. The deficiency impacted one (1) alcohol-based hand rub dispenser and could potentially impact any staff in the area. The findings were: Observation on 07/09/2025 at 10:00 AM in the break room revealed one (1) alcohol-based hand rub dispenser installed directly above or within one (1) inch of an electrical switch (ignition source). Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.6 (8)	K0325		
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.	K0353	The plant operations director created a policy and procedures in the facility CMMS program to ensure the five-year internal sprinkler pipe inspection is completed. SLHD will retain a certified fire sprinkler contractor to complete the five-year internal fire sprinkler piping inspection.	09/09/2025

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K0353 SS = D	Continued from page 29 Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain water-based fire protection systems in accordance with NFPA 101, Life Safety Code, and 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 impacted the fire sprinkler system and could potentially impact all residents, staff, and visitors. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed the facility failed to provide documentation of five (5) year internal inspection of sprinkler piping. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5 and 2010 NFPA 25, Section 14.2	K0353		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K0363	SLHD's plant operations director will create a policy and procedures for door inspection and operations in accordance with the 2012 NFPA 101 Life Safety Code. Trained maintenance staff will conduct monthly door checks during fire drills and routine maintenance rounds to ensure proper operation and functionality. The plant operations director will inspect all doors quarterly to ensure compliance.	09/09/2025

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K0363 SS = D	Continued from page 30 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 staff interview, the facility failed to maintain doors protecting corridors in accordance with 2012 NFPA 101, Life Safety Code. Failure to protect corridor openings could result in the obstruction of a corridor resulting in injury or death in the event of a fire. The deficiency affected one (1) of multiple corridor doors in the facility and could potentially impact any resident, staff, or visitors that utilize the corridor. The findings were: Observation on 07/09/2025 at 9:23 AM revealed the positive latching hardware on the corridor door leading to the basement mechanical room failed to latch keeping the door closed. Doors protecting corridor openings shall be self-latching and provided with positive latching hardware. Interview with the facility maintenance manager at the	K0363		

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K0363 SS = D	Continued from page 31 time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.3.6.3.5	K0363		
K0712 SS = F	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 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 under varied conditions could result in injury or death in the event of a fire. The deficiency could potentially impact all residents, staff, and visitors. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed the facility failed to provide fire drills quarterly on each shift under varied conditions. Fire drill documentation revealed fire drills conducted quarterly on each shift, but at similar times each quarter. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.7.1.6	K0712	The maintenance department will ensure the monthly fire drills are conducted at varied times throughout each shift, making sure at least one drill annually is while residents are sleeping.	09/09/2025
K0761 SS = D	Maintenance, Inspection & Testing - Doors	K0761	Annual fire door inspections conducted and documented.	09/09/2025

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K0761 SS = D	Continued from page 32 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) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of annual maintenance, inspection, and testing of fire doors in accordance with 2012 NFPA 101, Life Safety Code and 2010 NFPA 80, Standard for Fire Doors and Other Operating Protectives. Failure to inspect, test, and maintain fire doors could result in injury or death in the event of a fire. The deficiency affected one (1) of multiple fire doors and could potentially impact any resident, staff, or visitors in the area. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed the facility failed to provide documentation of annual maintenance, inspection and testing of one (1) rolling fire door at the cooking facility. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 8.3.3 and 2010 NFPA 80, Section 5.2.1	K0761	Continued from page 32 Doors repaired to meet 2012 NFPA 101 and 2011 NFPA 80 standards.	
K0918 SS = F	Electrical Systems - Essential Electric Syste	K0918	The plant operations director will implement a program	09/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St PO Box 390, Kemmerer, Wyoming, 83101

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K0918 SS = F	Continued from page 33 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 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 provide documentation of essential electrical systems annual testing and maintenance in accordance with 2012 NFPA 99, Healthcare Facilities Code. Failure to test, and maintain essential electrical systems could result in injury or death in the event of failure. The deficiency affected all essential electrical system feeders and breakers and could potentially impact all residents, staff, and visitors. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed the facility failed to provide documentation of annual testing and maintenance of essential electrical systems feeders and breakers.	K0918	Continued from page 33 for exercising the essential electrical systems feeders and breakers per the manufacturer requirements, and the 2012 NFPA 99. The POD will also ensure the program is added to the monthly PM schedule and the testing is documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

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K0918 SS = F	Continued from page 34 Essential electrical system main and feeder circuit breakers were not inspected annually, and a program for periodically exercising the components was not established according to manufacturer requirements. Written records of maintenance and testing were not maintained and readily available Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1.2	K0918		
K0921 SS = F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the	K0921	SLHD will retain a qualified electrical contractor to conduct the physical integrity, resistance, leakage current, and touch current tests testing on all PCREE. Testing intervals will be established by the POD (Plant Operations Director), and the POD will ensure electrical equipment instructions and manuals are readily available. Digital testing and maintenance records will be stored and maintained in the facilities CMMS program, and paper copies will be stored in a binder in the POD's office.	09/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

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K0921 SS = F	Continued from page 35 facility failed to provide documentation of Patient Care Related Electrical Equipment (PCREE) in accordance with 2012 NFPA 99, Healthcare Facilities Code. Failure to test and maintain PCREE could result in injury or death in the event of failure. The deficiency affected all PCREE and could potentially impact any resident or staff that utilize the equipment. The findings were: Document review on 07/09/2025 starting at 1:00 PM revealed the facility failed to provide physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE throughout the facility. Testing intervals were not established with policies and protocols. All PCREE used in patient care rooms was not tested before being put into service and after any repair or modification. Electrical equipment instructions and maintenance manuals were not readily available at the time of survey. A record of electrical equipment tests, repairs, and modifications were not maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirements. Interview with the maintenance and administrative staff at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 10.3, 10.5.2.1.1, 10.5.2.1.2, 10.5.3, 10.5.6	K0921		