STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crook County Medical Services District Long Term Care	713 Oak St , Sundance, Wyoming, 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/12/2025. 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 of Type II (111) construction built in 1985. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 32 certified Medicare and Medicaid beds with a census of 28 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0100 SS = D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain ceiling construction in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. The ceiling assembly is designed to trap hot air and gases around the sprinkler allowing the sprinkler to operate at a specified temperature. Failure to maintain the ceiling could allow hot air and gases to escape above the ceiling limiting the effectiveness of the fire sprinkler system. The deficiency affected (1) of multiple rooms. The deficiency could affect all staff who utilize the medication room. The findings were:	K0100		

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.

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K0100 SS = D	Continued from page 1 Observation and staff interview on 08/12/2025 at 1:25 PM revealed the facility failed to maintain the ceiling construction in the Medication room. Observation revealed an open ceiling grid where one (1) ceiling tile was removed from the ceiling allowing hot air and gases to escape the room limiting the effectiveness of the ceiling mounted fire sprinkler. Interview the facility maintenance manager at the time of the finding acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.1.1.1.3, 4.6.12.1, 9.7, 2010 NFPA 13, Section 8.5.4.1.1	K0100		
K0222 SS = D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection	K0222		

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K0222 SS = D	Continued from page 2 systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure delayed-egress locking arrangements were installed in accordance with the 2012 NFPA 101, Life Safety Code, Section 7.2.6.1.1. The deficiency affected one (1) delayed-egress locking door. The deficiency could lead to injury or death in the event of an emergency requiring egress from the facility. The deficiency could affect all residents, staff, and visitors attempting to utilize the exit. The findings were: Observations on 08/12/2025 at 1:50 PM revealed the delayed-egress locking door at the corridor exit failed to release the lock in the direction of egress within 15 seconds upon application of a force to the release device. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency.	K0222		

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K0222 SS = D	Continued from page 3 Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.4, and 7.2.1.6.1	K0222		
K0223 SS = D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure doors in a hazardous room are kept in the closed position in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure doors in a hazardous room are self-closing and remain in the closed position could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The findings were: Observations on 08/12/2025 at 1:30 PM revealed the linen storage room was equipped with a self-closing door due to the room being greater than 50 SF in size and the hazardous storage content within the room. Further observation revealed the self-closing door was fixed to an adjacent shelf, preventing the self-closing door from closing and remaining in the closed position. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency.	K0223		

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K0223 SS = D	Continued from page 4 Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.2.2.2.7	K0223		
K0324 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 STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance and testing for the kitchen range hood and kitchen extinguishing systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to provide maintenance and testing of kitchen range hoods and kitchen extinguishing systems could result in injury or death in the event of a fire in the kitchen. The deficiency affected one (1) commercial range hood and extinguishing system. The deficiency could affect all staff working in the kitchen. The findings were: Documentation review on 08/12/2025 beginning at 2:20 PM	K0324		

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K0324 SS = D	Continued from page 5 revealed the facility failed to provide evidence of testing and maintenance of listed hoods every 6 months in accordance with the 2011 NFPA 96, Section 11.5. Documentation indicated the facility tested the listed hood at intervals exceeding 6 months. Interview with the facility maintenance manager at the time of observation acknowledged the deficiencies. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.3.2.5.1, 9.2.3, and 2011 NFPA 96, Sections 11.4, 11.5	K0324		
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain and provide documentation of required maintenance for the water-based fire protection systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire	K0353		

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K0353 SS = E	Continued from page 6 protection systems could result in injury or death in the event of a fire. The deficiency could affect the entire fire sprinkler system. The deficiency could affect all residents, staff, and volunteers at the facility. The findings were: Observation on 08/12/2025 at 1:07 PM revealed a sprinkler system gauge in the fire riser with an installation date of 01/09/2020. Document review on 08/12/2025 starting at 2:20 PM revealed the facility failed to provide evidence of replacement or testing of gauges in accordance with the 2010 NFPA 25, which requires gauges to be replaced every five (5) years or tested every five (5) years by comparison with a calibrated gauge. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiencies. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Section 5.3.2.1	K0353		
K0751 SS = E	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is NOT MET as evidenced by: Based on observation, document review, and staff interview, the facility failed to provide documentation that patient privacy curtains were in accordance 2012 NFPA 101, Life Safety Code, Section 10.3.1. Failure to provide privacy curtains in accordance with Section 10.3.1 could contribute to flame spread rate in resident rooms in the event of a fire, leading to	K0751		

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K0751 SS = E	Continued from page 7 injury or death. The deficiency affected multiple resident rooms. The findings were: Document review on 08/12/2025 beginning at 2:20 PM revealed the facility failed to provide documentation ensuring the privacy curtains failed to meet the flame propagation performance criteria contained in the 2012 NFPA 101, Section 10.3.1. Observation on 08/12/2025 at 4:30 PM in room 217 revealed the privacy curtain did not include manufacturer's documentation of flame propagation performance criteria contained in NFPA 701. The facility failed to provide secondary documentation showing compliance. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections 19.7.5, 10.3.1	K0751		
K0918 SS = E Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 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	K0918		

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K0918 SS = E Bldg. 01	Continued from page 8 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 ensure essential electrical systems were tested and maintained in accordance with the 2012 NFPA 99 Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to test and maintain essential electrical systems could lead to loss of essential electrical power resulting in injury or death in the event of electrical system failure. The deficiency could impact residents, staff, and visitors in areas affected by an electrical system failure. The findings were: Document review on 08/12/2025 starting at 2:20 PM revealed the facility failed to provide evidence of the following essential electric system maintenance and testing in accordance with the 2010 NFPA 110, Standard for Emergency and Standby Power Systems: 1. Evidence of an annual testing and maintenance program for essential electrical system feeders and breakers in accordance with manufacturer's recommendations. Documentation revealed the facility tested the essential electrical system feeders and breakers at frequencies exceeding 12 months. 2. Evidence the facility exercised the emergency generator once every 36 months for 4 continuous hours under load conditions. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1.2.1, and 2010 NFPA 110, Section 8.4.9	K0918		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/12/2025. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		
E0026 SS = F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(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:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. 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 in accordance	E0026		

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E0026 SS = F	Continued from page 1 with §483.73(b)(8). The EPP failed to outline the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. The findings were: Review of the EPP on 08/12/2025 starting at 2:20 PM revealed that the facility's EPP failed develop and implement policies and procedures describing the facility's role in providing care under section 1135 waivers during a declared public health emergency in alternate care sites. Interview with the facility maintenance manager and the facility administrator, along with document review at the time of observation, acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0026		
E0031 SS = F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E0031		

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(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
E0031 SS = F	Continued from page 2 emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This 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 a communication plan in accordance with §483.73(c)(2). Failure to provide a communication plan with the required contact information could delay response in the event of an emergency leading to injury or death. The deficiency could affect all residents, staff, and visitors in the case of an emergency. The findings were: Review of the facility EPP on 08/12/2025 starting at 2:20 PM revealed that the facility had included a communication plan, but failed to provide the required contact information for federal emergency preparedness officials. Interview with the facility maintenance manager and the facility administrator, along with document review at the time of observation, acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0031		
E0037 SS = F	EP Training Program 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),	E0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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E0037 SS = F	Continued from page 3 §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 nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency	E0037		

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E0037 SS = F	Continued from page 4 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. (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	E0037		

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E0037 SS = F	Continued from page 5 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 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	E0037		

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E0037 SS = F	Continued from page 6 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 evidence of an emergency preparedness training program that includes annual training for all staff, individuals providing service under arrangement, and volunteers, consistent with their expected roles in accordance with §483.73(d)(1). Failure to provide an annual emergency preparedness training program could result in injury or death in the event of an emergency. The deficiency could affect all residents, staff, and volunteers in the case of an emergency. The findings were: Review of the Emergency Preparedness Plan on 08/12/2025 starting at 2:20 PM revealed that the facility provided initial training for new staff, but failed to provide evidence of emergency preparedness training at least annually for all staff, individuals providing services under arrangement, and volunteers consistent with their expected roles. Interview with the facility maintenance manager and the	E0037		

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E0037 SS = F	Continued from page 7 facility administrator at the time of observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0037		
E0041 SS = F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3),	E0041		

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E0041 SS = F	Continued from page 8 §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.	E0041		

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E0041 SS = F	Continued from page 9 (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 110, Life Safety Code in accordance with §483.7(e)(2). Failure to provide the required inspection, testing, and maintenance of emergency power systems could lead to injury or death for all residents and staff in the event of an electrical system failure or emergency. The findings were: Document review on 08/12/2025 starting at 2:20 PM revealed the facility failed to provide evidence of the following emergency generator inspection and testing requirements in accordance with the 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 101, Life Safety Code: 1. Annual testing and maintenance for essential electrical system feeders and breakers. The facility failed to provide evidence that a program for periodically exercising the components has been established in accordance with manufacturer's recommendations. 2. The facility failed to exercise the emergency generator once every 36 months for 4 continuous hours under load conditions. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency.	E0041		