STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531501	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - CHAPMAN HOUSE B. WING	01/13/2026 FEB 10 2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Wyoming Hospice Program	319 South Wilson Street , Casper, Wyoming, 82601

(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 at the Chapman building on 01/13/2026. Requirements for Hospices Section 42 CFR 418.110, except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) construction built in 1986, and remodeled in 2008. The building was equipped with a supervised automatic sprinkler system with a wet antifreeze loop, and an addressable fire alarm system. The facility had an overall capacity of 18 certified Medicare and Medicaid beds with an overall census of 13 residents. The findings that follow demonstrate noncompliance with 42 CFR 418.110.	K0000		
K0223	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.	K0223	1.Maintenance fixed the doors on 1/30/26. The Director of Administration confirmed the doors latched properly on 2/6/26. 2. The DA will ensure that checking the self closing doors is a monthly task to be completed by Maintenance in the TELS facility management system. 3. The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Checking self closing doors will be included in a monthly reporting to Safety QAPI.	

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
[signature]	CEO	2/6/26

I spoke to the facility Administrator on 2/13/26@9:35am to inform her of plan acceptance. #4673

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHAPMAN HOUSE B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Wyoming Hospice Program	319 South Wilson Street , Casper, Wyoming, 82601

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K0223	Continued from page 1 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 in the Chapman Building, the facility failed to ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position unless held open by a release device in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure self-closing doors close and latch could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected one (1) of multiple doors and could potentially affect all residents, staff, and visitors. The findings were: Observation on 01/13/2026 at 9:50 AM in the Chapman building revealed the Janitor's Closet was protected with a fire rated self-closing door. Further observation revealed the self-closing door failed to close and latch when dropped from the open position. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.7, 19.3.2.1, 19.3.2.1.3	K0223		
K0291	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 and exit signs at the Chapman building in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test battery-operated emergency lighting equipment as required could result in inadequate	K0291	1. The 30 sec functional testing was completed by the maintenance man on 1/31/26. 2. The DA provided Maintenance on the testing requirements. 3. The DA will confirm that functional testing of the lights is part of the TELS system by 2/20/26. 4. The DA will review the TELS task list monthly with Maintenance to ensure completion. 5. 30 Sec functional testing will be included in monthly reporting to the Safety QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	531501	A. BUILDING 01 - CHAPMAN HOUSE B. WING	01/13/2026

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K0291	Continued from page 2 lighting or failure to identify exit access during an emergency, resulting in injury or death. The deficiency impacted all battery powered exit signage and emergency lighting throughout the facility. The findings were: Document review on 01/13/2026 starting at 11:00 AM revealed the facility failed to provide evidence of required 30 second functional testing of the battery-operated emergency lighting and exit signs at the Chapman building for the months of July and August of 2025. The 2012 NFPA 101, section 7.9.3.1.1 requires monthly functional testing of battery powered emergency lighting and exit signs for not less than 30 seconds. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.9, 19.2.10, 7.9.3.1, 7.10.9.2	K0291		
K0353	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	K0353	1. Maintenance completed the 5 year sprinkler system inspection on 1/26/26. 2. The DA will confirm that the 5 years inspection is part of TELS system by 2/20/26. 3. The DA will review the TELS task list on a monthly basis with Maintenance to ensure completion.	

This STANDARD is NOT MET as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHAPMAN HOUSE B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0353	Continued from page 3 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 at the Chapman Building in accordance with 2012 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 could affect the entire fire sprinkler system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 01/13/2026 starting at 11:00 AM for the Chapman building revealed the facility failed to provide evidence of internal inspection of piping as required by the 2011 NFPA 25, section 14.2. An internal inspection of the fire sprinkler system's piping and branch line conditions shall be conducted every 5 years. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Section 14.2	K0353		
K0712	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:	K0712	1.The DA educated Maintenance on the importance and regulatory requirements of fire drills on 1/29/26. 2. Maintenance completed fire drills for all shifts on 1/31/26. 3. The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Fire Drills will be included in monthly reporting to Safety QAPI.	

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K0712	Continued from page 4 Based on document review and staff interview, the facility failed to provide documentation of fire drills conducted quarterly on each shift under varied conditions at the Chapman building in accordance with 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills quarterly for all shifts and under varied conditions could lead to confusion or delay response resulting in injury or death in the event of a fire emergency. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 01/13/2026 starting at 11:00 AM revealed the facility failed to conduct fire drills quarterly on each shift under varied conditions at the Chapman building. The facility failed to provide evidence of a second shift fire drill occurring during the fourth quarter of 2025. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.7.1	K0712	1. The DA educated Maintenance on the importance and regulatory requirements of fire drills on 1/29/26. 2. Maintenance completed fire drills for all shifts on 1/31/26. 3. The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Fire Drills will be included in a monthly reporting to Safety QAPI.	
K0918	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	K0918	1.The DA educated the Maintenance on regulatory requirements on 2/6/26. 2.Maintenance will have an electrician inspect the EPSS circuit breakers by 2/27/26. 3.The DA will add breaker inspection of the generator to the TELS system by 2/20/26. 4.The DA will review the TELS task list monthly with Maintenance to ensure completion.	

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K0918	Continued from page 5 exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 110, Life Safety Code. 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 deficiency affected all of the emergency power systems at the Chapman building. The deficiency could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/13/2026 starting at 11:00 AM revealed the facility's Emergency Power Supply Systems for the Chapman building were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following: Emergency Power Supply System (EPSS) main and feeder circuit breakers shall be inspected annually and a program established for exercising components per manufacturer's recommendations. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1.2, and 2010 NFPA 110, Section 8.4.9	K0918		
K0923	Gas Equipment - Cylinder and Container Storag	K0923		

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K0923 Bldg. 01	Continued from page 6 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly handle and store gas cylinders in the Chapman building in accordance with 2012 NFPA 99, Healthcare Facilities Code. Failure to properly handle and store compressed gas cylinders could result in injury or death in the event of accident or fire. The deficiency could affect all residents, staff, and	K0923	1. Maintenance removed the excess tanks on 1/27/26. 2. Maintenance placed proper precautionary signage on 2/6/26. 3. The DA will place educational signage in the oxygen rooms to remind nurses that there may only be 12 tanks by 2/13/26. The DCS will educate nursing staff about oxygen storage requirements by 2/27/26. 4. The DA will confirm that checking the oxygen closet for signage and proper storage is part of the TELS system by 2/20/26. 5. The DA will review the TELS task list on a monthly basis with Maintenance to ensure completion. 6. Proper oxygen storage will be included in a monthly reporting to Safety QAPI.	

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		A. BUILDING 01 - CHAPMAN HOUSE B. WING	01/13/2026

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K0923	Continued from page 7 visitors within the affected area. The findings were: Observations on 01/13/2026 at 10:08 AM in the Chapman building revealed the facility failed to provide proper storage for nonflammable gas cylinders. The facility allowed for storage of compressed oxygen E-cylinders with a total volume greater than 300 cu. ft. compressed to be stored in an interior storage room within 5 ft of combustible supplies. Further observations of the oxygen storage room in the Chapman building revealed the facility failed to provide the proper precautionary signage in accordance with the 2012 NFPA 99, section 11.3.4. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99 Section 11.3, 11.3.2, 11.3.3, 11.3.4	K0923		
Bldg. 01				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - KLOEFKORN HOUSE B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Wyoming Hospice Program	319 South Wilson Street , Casper, Wyoming, 82601

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K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys at the Kloefkorn building on 01/13/2026. Requirements for Hospices Section 42 CFR 418.110, except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) construction built in 2009. The building was equipped with a supervised automatic sprinkler system with a wet antifreeze loop, and an addressable fire alarm system. The facility had an overall capacity of 18 certified Medicare and Medicaid beds with an overall census of 13 residents. The findings that follow demonstrate noncompliance with 42 CFR 418.110.	K0000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in the Kloefkorn Building in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress could lead to injury or death in the event of an emergency. The deficiency affected one (1) of multiple	K0211	1. Maintenance fixed the doors on 1/30/26. The Director of Administration confirmed the doors latched properly on 2/6/26. 2.The DA will ensure that checking the self closing doors is a monthly task to be completed by Maintenance in the TELS facility management system. 3.The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Check operation of corridor doors will be included in a monthly reporting to Safety QAPI.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	2/6/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531501	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 02 - KLOEFKORN HOUSE B. WING	01/13/2026

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K0211	Continued from page 1 means of egress. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Observation on 01/13/2026 at 10:27 AM revealed a pair of 3/4 hour fire rated cross corridor doors with hold open devices in the exit access corridor in the Kloefkorn building. Both doors closed and latched when dropped from their magnetic hold open devices. Further observations revealed the exit hardware on the east door failed to release the door latch leaving the door inoperable after it closed. The inoperable door created an obstruction within the means of egress. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.10.1, 7.2.1.5.1	K0211		
K0223	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:	K0223	1. Maintenance fixed the doors on 1/30/26. The Director of Administration confirmed the doors latched properly on 2/6/26. 2. The DA will ensure that checking the self closing doors is a monthly task to be completed by Maintenance in the TELS facility management system. 3. The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Checking self latching doors will be included in a monthly reporting to Safety QAPI.	

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K0223	Continued from page 2 Based on observation and staff interview in the Kloefkorn Building, the facility failed to ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position unless held open by a release device in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure self-closing doors close and latch could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected one (1) of multiple doors and could potentially affect all residents, staff, and visitors. The findings were: Observation on 01/13/2026 at 10:39 AM in the Kloefkorn building revealed the Pantry storage room was protected with a fire rated self-closing door. Further observation revealed the self-closing door failed to close and latch when dropped from the open position. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.7, 19.3.2.1, 19.3.2.1.3	K0223		
K0291	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 and exit signs at the Kloefkorn building in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test battery-operated emergency lighting equipment as required could result in inadequate lighting or failure to identify exit access during an emergency, resulting in injury or death. The deficiency impacted all battery powered exit signage and emergency lighting throughout the facility. The findings were:	K0291	1.The 30 sec functional testing was completed by the maintenance man on 1/31/26. 2. The DA provided Maintenance on the testing requirements. 3. The DA will confirm that functional testing of the lights is part of the TELS system by 2/20/26. 4. The DA will review the TELS task list monthly with Maintenance to ensure completion. 5. 30 Sec functional testing will be included in monthly reporting to the Safety QAPI.	

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		A. BUILDING 02 - KLOEFKORN HOUSE B. WING	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Wyoming Hospice Program	319 South Wilson Street , Casper, Wyoming, 82601

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K0291	Continued from page 3 Document review on 01/13/2026 starting at 11:00 AM revealed the facility failed to provide evidence of required 30 second functional testing of the battery-operated emergency lighting and exit signs at the Kloefkorn building for the months of July and August of 2025. The 2012 NFPA 101, section 7.9.3.1.1 requires monthly functional testing of battery powered emergency lighting and exit signs for not less than 30 seconds. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.9, 19.2.10, 7.9.3.1, 7.10.9.2	K0291		
K0353	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	K0353	1.Maintenance completed the 5 year sprinkler system inspection on 1/26/26. 2. The DA will confirm that the 5 years inspection is part of TELS system by 2/20/26. 3. The DA will review the TELS task list on a monthly basis with Maintenance to ensure completion.	

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K0353	Continued from page 4 water-based fire protection systems at the Kloefkorn Building in accordance with 2012 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 could affect the entire fire sprinkler system. The findings were: Document review on 01/13/2026 starting at 11:00 AM for the Kloefkorn building revealed the facility failed to provide evidence of internal inspection of piping as required by the 2011 NFPA 25, section 14.2. An internal inspection of the fire sprinkler system's piping and branch line conditions shall be conducted every 5 years. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Section 14.2	K0353		
K0712	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 at the Kloefkorn building in accordance with 2012 NFPA 101, Life Safety Code. Failure to conduct fire drills quarterly for all shifts and under varied	K0712	1.The DA educated Maintenance on the importance and regulatory requirements of fire drills on 1/29/26. 2. Maintenance completed fire drills for all shifts on 1/31/26. 3. The DA will review the TELS task list monthly with Maintenance to ensure completion. 4. Fire Drills will be included in a monthly reporting to Safety QAPI.	

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K0712	Continued from page 5 conditions could lead to confusion or delay response resulting in injury or death in the event of a fire emergency. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 01/13/2026 starting at 11:00 AM revealed the facility failed to conduct fire drills quarterly on each shift under varied conditions at the Kloefkorn building. The facility failed to provide evidence of a second shift fire drill occurring during the fourth quarter of 2025. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 19.7.1	K0712		
K0918	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 available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of	K0918	1. The DA educated the Maintenance on regulatory requirements on 2/6/26. 2. Maintenance will have an electrician inspect the EPSS circuit breakers by 2/27/26. 3. The DA will add breaker inspection of the generator to the TELS system by 2/20/26. 4. The DA will review the TELS task list monthly with Maintenance to ensure completion.	

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K0918	Continued from page 6 the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 110, Life Safety Code. 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 deficiency affected all emergency power systems at the Kloefkorn building. The deficiency could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/13/2026 starting at 11:00 AM revealed the facility's Emergency Power Supply Systems for the Kloefkorn building were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following: Emergency Power Supply System (EPSS) main and feeder circuit breakers shall be inspected annually and a program established for exercising components per manufacturer's recommendations. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1.2, and 2010 NFPA 110, Section 8.4.9	K0918		
K0923 Bldg. 02	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K0923		

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K0923 Bldg. 02	Continued from page 7 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly handle and store gas cylinders in the Kloefkorn building in accordance with 2012 NFPA 99, Healthcare Facilities Code. Failure to properly handle and store compressed gas cylinders could result in injury or death in the event of accident or fire. The deficiency could affect all residents, staff, and visitors within the affected area. The findings were: Observations on 01/13/2026 at 10:20 AM in the Kloefkorn building revealed the facility failed to provide proper storage for nonflammable gas cylinders. The facility allowed for storage of compressed oxygen E-cylinders	K0923	1. Maintenance removed the excess tanks on 1/27/26. 2. Maintenance placed proper precautionary signage on 2/6/26. 3. The DA will place educational signage in the oxygen rooms to remind nurses that there may only be 12 tanks by 2/13/26. The DCS will educate nursing staff about oxygen storage requirements by 2/27/26. 4. The DA will confirm that checking the oxygen closet for signage and proper storage is part of the TELS system by 2/20/26. 5. The DA will review the TELS task list monthly with Maintenance to ensure completion. 6. Proper oxygen storage will be included in a monthly reporting to Safety QAPI.	

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K0923 Bldg. 02	Continued from page 8 with a total volume greater than 300 cu. ft. compressed to be stored in an interior storage room within 5 ft of combustible supplies. Further observations of the oxygen storage room in the Kloefkorn building revealed the facility failed to provide the proper precautionary signage in accordance with the 2012 NFPA 99, section 11.3.4. Interview with the facility maintenance manager and the facility administrator at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99 Section 11.3, 11.3.2, 11.3.3, 11.3.4	K0923		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 01/13/2026. The findings that follow demonstrate noncompliance with 42 CFR 418.113.	E0000		
E0026	Roles Under a Waiver Declared by Secretary CFR(s): 418.113(b)(6)(C)(iv) §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	1. The Executive Director will edit the Emergency Preparedness manual to include provisions of care under a 1135 waiver by 2/20/26. 2. The Safety Committee will review the Emergency preparedness manual on 2/25/26. 3. The ED and the Safety Committee will review and update the Emergency preparedness manual every December.	

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
[signature]	CEO	2/6/26

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E0026	Continued from page 1 with §418.113(b)(6)(C)(iv). 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 01/13/202 starting at 11:00 AM revealed that the facility's EPP failed to develop and implement policies and procedures which outline the facility's role in the provision of care and treatment under section 1135 waivers during a declared public health emergency in alternate care sites. Interview with the facility administrator and the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator and the facility maintenance manager at the time of exit confirmed the deficiency.	E0026		