STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Rehabilitation and Care Center	2700 E 12th Street , Cheyenne, Wyoming, 82001

(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 01/14/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90, 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 (000) construction built in 1961. The building was equipped with a supervised automatic wet sprinkler system with a wet antifreeze sprinkler system, and an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 69 residents. The findings that follow demonstrate noncompliance with 42 CFR 48.90.	K0000		02/09/2026
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	K0223	No residents were identified in deficiency; door latch was repaired on 1-15-2026 by maintenance director and closes/latches appropriately. All Residents could be affected. All door latches were tested on 1-15-2026 and found to be working appropriately. Administrator educated Maintenance Director on 1-15-2026 on door operation and appropriate closure/latch securement. Administrator or designee will Audit doors 1x/per week for 4 weeks, by weekly x 2 weeks and Monthly x 3 months to ensure that doors appropriately close and latch. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

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K0223 SS = D	Continued from page 1 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 deficiency affected one (1) of multiple doors. The findings were: Observations on 01/14/2026 at 11:11 AM revealed the south door separating the Yellowstone hall from the facility was protected with a self-closing door. Further observation revealed the self-closing door failed to latch, and keep the door in the closed position when dropped. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7.1	K0223		
K0271 SS = D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide an exit discharge that provides a level walking surface meeting the provisions of 2012 NFPA 101, Life Safety Code with respect to abrupt changes in walking surfaces in the means of egress. Failure to provide a level walking surface at the means of egress could delay or impede egress in an emergency leading to injury or death. The deficiency affected one	K0271	No residents were identified in deficiency; concrete was ground down on 2-1-2026 by maintenance director to specifications of 1/4 inch or less. All Residents could be affected. All exit doors were audited for elevation changes in concrete of over ¼ inch and no addition areas were found. Administrator educated Maintenance Director on 1-15-2026 concrete walking surfaces not having more then ¼ inch difference between concrete pieces. Administrator or designee will Audit concrete 1x/per week for 4 weeks, by weekly x 2 weeks and Monthly x 3 months to ensure that no elevation change is over ¼ inch between concrete pieces. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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K0271 SS = D	Continued from page 2 (1) of multiple exits. The deficiency could affect all residents, staff, and visitors. The findings were: Observation on 01/14/2026 at 11:22 AM revealed the exit path from the Yellowstone hall (North West exit) to the public way included a concrete walking surface with an abrupt change in elevation of walking surface in excess of one-quarter inch (1/4") 2012 NFPA 101, Life Safety Code, specifies that abrupt changes in elevation of walking surfaces shall not exceed one-quarter inch (1/4”). Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.6	K0271		
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 * 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	K0325	No residents were identified in deficiency; Maintenance removed over stock of hand sanitizer from storage room by conference room on 1-14-26. All Residents could be affected. All corridors were audited on 1-15-2025 and found no other corridors with over 5 gallons of sanitizer in storage. Administrator educated Maintenance Director on 1-15-2026 and Housekeeping Manager on not storing over 5 gallons of sanitizer on the same corridor. Administrator or designee will audit 1x/per week for 4 weeks, by weekly x 2 weeks and Monthly x 3 months to ensure no more than 5 gallons are stored in the corridor. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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K0325 SS = D	Continued from page 3 * 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 store Alcohol-Based Hand-Rub (ABHR) in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 30, Flammable and Combustible Liquids Code . Failure to store ABHR as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of several storage rooms in the facility. The findings were: Observation on 01/14/2026 at 11:05 AM at the storage room next to the conference room, revealed that there was in excess of 5 gallons of ABHR. Total quantity of ABHR was 22.5 Liters, approximately six (5.94) gallons. The storage room was less than one hundred (100) sq ft in area, and the door had a closure. However the room was non fire-rated. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 19.3.2.3(7) 2012 NFPA 30 Sections 9.7.1, 9.7.2, Tables 9.6.2.1, 9.7.2	K0325		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K0345	K 0345 A No residents were identified in deficiency; Previous month were deficiency was noted could not be corrected. All Residents could be affected. All months since August 2025 were audited and found in compliance with regulation. Administrator educated Maintenance Director on 1-15-2026 that fire alarm documentation must be had to show that the alarm system rang to monitoring company. Administrator or designee will audit Monthly x 3 months	02/11/2026

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K0345 SS = F	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of maintenance for the fire alarm system in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency could affect the entire fire alarm system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Document review on 01/14/2026 starting at 3:45 PM revealed the facility failed to provide documentation of testing and maintenance of the fire alarm system in accordance with 2010 NFPA 72. The facility failed to provide documentation of the following tests: a) Monthly activation of supervising station alarm systems - Table 14.4.5(24) b) Annual Alarm notification devices location based pass/fail - Table 14.4.5(20); 14.6.2.4, Figure 14.6.2.4 page 11 Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.1.6.3, 9.6.1.5, and 2010 NFPA 72, Section 14.4.5, 14.6.2.4; Table 14.4.5; Figure 14.6.2.4	K0345	Continued from page 4 to the documentation on the alarm system ringing to the monitoring company took place. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs. K 0345 B No residents were identified in deficiency; Facility Contractor Came on site on 1-21-26 to inspect/update that the alarm device locations and the pass/fail of devices were put onto annual report. All Residents could be affected. No other annual reports are due at this time. Administrator educated Maintenance Director on 1-15-2026 that annual report must show the alarm device locations and pass/fail of devices. Administrator or designee will audit 1x that annual report received from Facility Contractor has the alarm device locations and Pass/Fail were documented. Audit will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	
K0351 SS = E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K0351	Rooms 141,142,143,145,146, and 147 had the items removed that were within 18 inches of the fire sprinklers/ceiling on 2-4-2026. All Residents could be affected. All rooms were audited on 1-15-2026 and found no other rooms were affected. Administrator educated Maintenance Director on 1-15-2026 and current staff at all staff on 2-5-2026 about not having any items withing 18 inches of the ceiling/ sprinklers. Administrator or designee will audit 10 rooms/per week for 4 weeks, 10 rooms by weekly x 2 weeks and Monthly x 3 months to ensure no more items are within 18 inches of sprinklers/ceiling. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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K0351 SS = E	Continued from page 5 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure proper installation of the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to ensure proper installation of the fire sprinkler systems could result in injury or death in the event of a fire. The deficiency affected multiple fire sprinklers throughout the facility. The deficiency could affect all residents, staff, and volunteers in the facility. The findings were: Observation on 01/14/2026 starting at 10:25 AM revealed the facility failed to provide adequate clearance between the fire sprinkler system and the storage in multiple resident room closets including rooms 141, 142, 143, 145, 146, and 147. The storage was within eighteen inches (18") of the ceiling-mounted fire sprinkler deflectors creating an obstruction to sprinkler discharge pattern development. Interview with the facility maintenance manager at the time of the observations acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, 2010 NFPA 13 Section 8.5.6	K0351		
K0511 SS = D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.	K0511	No residents were identified in deficiency; Maintenance Director placed a cable to prevent gas fired cooking appliance from stretching flexible gas piping on 1-21-2026. All Residents could be affected. All gas appliances were audited, and no other appliances were affected. Administrator educated Maintenance Director on 1-15-2026 about the restraint needing to be in place for all gas appliances with flexible hoses.	02/11/2026

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K0511 SS = D	Continued from page 6 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to maintain gas-fired equipment could lead to system damage and failure, resulting in injuries to staff or residents. The deficiency affected the kitchen, and all staff working within. The findings were: Observation on 01/14/2026 at 10:07 AM in the kitchen revealed gas-fired cooking appliances. Further observation revealed that the appliances were on casters, and the cook-top was provided with the required restraint to protect the flexible gas piping when the appliances are moved for service or cleaning. However, the oven was did not have a restraint to protect the flexible gas piping when the appliance was moved.. Interview with facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.5.1.1; 9.1.1 2012 NFPA 54, Section 9.6.1.2	K0511	Continued from page 6 Administrator or designee will audit Monthly x 3 months that gas appliance restraints are in place. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	
K0521 SS = E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test fire dampers in accordance with the 2012 NFPA 101, Life Safety Code; 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems; 2010 NFPA 80, Standard for Fire	K0521	No residents were identified in deficiency; 4-year internal dampener inspection was completed on 2-9-2026. All Residents could be affected. All Dampeners were inspected on 2-9-2026 Administrator educated Maintenance Director on 1-15-2026 that all dampeners must be inspected every 4-years internally to ensure that they close appropriately. Administrator or designee will audit 1 month that annual inspection was completed on2-9-2026. Audits will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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K0521 SS = E	Continued from page 7 Doors and Other Opening Protectives. Failure to inspect and maintain fire dampers could result in injury or death in the event of a fire. The deficiency affected all fire dampers throughout the facility. The findings were: Document review on 01/14/2026 starting at 12:30 PM revealed the facility failed to ensure fire dampers were inspected and maintained every four (4) years in accordance with 2010 NFPA 80 section 19.4.1.1. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.5.2, 9.2.1, 2012 NFPA 90A, Section 5.4.8, 2010 NFPA 80, Section 19.4.1.1	K0521		
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete 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.	K0918	No residents were identified in deficiency; Facility Contracted Electrician to do the annual test of the emergency panels feed/breakers on 2-4-26. No issues were noted and panel passed. All Residents could be affected. Facility Contracted Electrician to do the annual test of the emergency panels feed/breakers on 2-4-26. No issues were noted and panel passed. Administrator educated Maintenance Director on 1-15-2026 on annual test needed on emergency panel feeds and breakers. Administrator or designee will audit 1x that annual audit was completed on 2-4-26. Audit will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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K0918 SS = F	Continued from page 8 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. The deficiency affected all emergency power systems. 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 01/14/2026 starting at 12:30 PM revealed the facility's Emergency Power Supply Systems 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: 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. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1	K0918		
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for	K0920	No residents were identified in deficiency; Maintenance Director removed additional power strip on 1-14-2026. All Residents could be affected. Maintenance Director did an audit of all power strips on 1-15-26 and did not identify any other issues. Administrator educated Management Team on 1-15-2026 to not have a power strip plugged into another power strip. Administrator or designee will audit 5 areas weekly/4 weeks, Bi weekly by 2 and monthly by 3 month that there are no daisy chained power strips. Audit will be brought to Monthly QAPI for review and assessment of	02/11/2026

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K0920 SS = D Bldg. 01	Continued from page 9 non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide approved power strips in accordance with 2012 NFPA 99 Health Care Facilities Code. The use of power cords that are not in compliance with 2012 NFPA 99, could increase the risk of electrical failure resulting in injury or death. The deficiency could impact all residents and staff within the affected smoke compartment. The findings were: Observation on 01/14/2026 at 9:26 AM revealed multiple power strips were daisy-chained together at the Front Desk. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, 10.2.3.6, 10.2.4	K0920	Continued from page 9 compliance/future audit needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Rehabilitation and Care Center	**2700 E 12th Street , Cheyenne, Wyoming, 82001**

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 01/14/26. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		01/30/2026
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	E0041	No residents were identified in deficiency; Facility Contracted Electrician to do the annual test of the emergency panels feeds/breakers on 2-4-26. No issues were noted and panel passed. All Residents could be affected. Facility Contracted Electrician to do the annual test of the emergency panels feed/breakers on 2-4-26. No issues were noted and panel passed. Administrator educated Maintenance Director on 1-15-2026 on annual test needed on emergency panel feeds and breakers. Administrator or designee will audit 1x that annual audit was completed on 2-4-26. Audit will be brought to Monthly QAPI for review and assessment of compliance/future audit needs.	02/11/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

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E0041 SS = F	Continued from page 1 [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), §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.	E0041		

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E0041 SS = F	Continued from page 2 (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. (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. The deficiency affected all emergency power systems. 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 01/14/2026 starting at 12:30 PM revealed the facility's Emergency Power Supply Systems 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: 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. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1.2.1	E0041		