DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53C0001006	A. BUILDING 01 - MAIN BUILDING B. WING	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Bone and Joint Ambulatory Surgical Center	1909 Vista Drive , Laramie, Wyoming, 82070

(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 04/13/2026. Requirements for Ambulatory Surgical Centers, Section CFR 416.44(b), except as otherwise provided in this section, Building A must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Ambulatory Health Care, of the National Fire Protection Association. Building B must meet the applicable provisions of the 2012 Edition of the Life Safety Code, New Ambulatory Health Care, of the National Fire Protection Association. Building A was a single story building with a basement of type V(111) construction built in 1978, with an OR addition built in 1995. A second addition with a supervised, automatic wet sprinkler system was constructed in 1998. The entire facility was equipped with a zoned fire alarm system. The licensed and certified portion of the building was separated from the remainder of the non-sprinklered portions by fire-rated construction. Building B was a single story building of type II (000) construction equipped with a supervised, automatic wet sprinkler system, and a zoned fire alarm system constructed in 2019. The findings that follow demonstrate noncompliance with 42 CFR 416.44.	K0000	PoC accepted via Phone call w/ Nicole Becker on 04/27/26 @ 10:30AM. Doc: 5/22/26 33647. - 4/13/26 dates manually changed to 4/14/26 by HLS. Approved via call w/ Nicole Becker on 4/28/26 @ 10:30AM. In response to K0353: 1. Summit Fire Protection has provided the scheduled quarterly/annual inspection dates so that PBJC can also track scheduling and verify inspections have been completed successfully. 2. PBJC verified with Summit Fire Protection that the facility quarterly inspections have been updated in their system since their merger with Front Range Fire Protection (performed quarterly inspections prior to the merger). 3. Summit Fire Protection will reach out to PBJC with a copy of each quarterly inspection so the inspections logs can be kept updated. 4. PBJC will communicate directly with Summit Fire Protection for all scheduling to ensure no future inspections are missed. 5. Summit Fire Protection performed an onsite inspection on 4/14/26 and the results have been added to the log. The water supply source is City. 6. This is assigned to the Director of Facilities to monitor and verify compliance.	
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	K0353		

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other ifeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 ys 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 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program irticipation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ASC Director	4-23-26

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K0353	Continued from page 1 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 document review, observation, and staff interview, the facility failed to maintain and test sprinkler 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 maintain and test sprinkler systems as required may inhibit the ability of the system to respond to a fire, which may lead to injury or death in an emergency. The deficiencies were noted in documentation, and were also observed in one (1) of multiple areas with storage, and could impact all staff, residents, and visitors in the area of observation. The findings were: Observation on 04/13/2026 at 11:54 AM in the laundry room revealed boxes stored on top of laundry equipment. These boxes were located less than 18 inches below the overhead sprinkler deflector, resulting in an obstruction to water flow. A minimum of 18 inches must be maintained below all sprinkler deflectors to prevent obstructions to the coverage area. Interview with facility maintenance staff at the time of observation confirmed the deficiency, and indicated he was aware of the requirement. Interview with the facility's director of nursing at the time of exit confirmed the deficiency. REF: 2011 NFPA 25, Section 5.2.1.2. Document review on 04/13/2026 starting at 10:30 AM revealed that the facility failed to perform quarterly testing and inspections of the sprinkler system. Review identified that quarterly testing of dry systems had been performed in February and August of 2025, as well as February of 2026. No additional testing documentation was provided. These systems must be tested at least quarterly to ensure proper system operation.	K0353	In response to K0353 cont. 1. The boxes on top of the laundry equipment was found to belong to the physical therapy department. The Director of Facilities and ASC Director notified the Director of Physical Therapy of the deficiency. 2. The items identified during the inspection were removed on 4/14/26. 3. Random audits will be performed once a week x 4 weeks. then once a month x 3 months. If failure of compliance is identified, audits will continue as deemed necessary until compliance is reached. This is assigned to the Clinical Education Coordinator. 4. Results of the audits will be reported to the QAPI committee.	

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K0353	Continued from page 2 Interview with facility maintenance staff at the time of observation confirmed that documentation was unavailable. Additional post-survey coordination between the facility and their contractor confirmed that these tests were not performed. The facility maintenance staff indicated that he was aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency. REF: 2011 NFPA 25, Table 5.1.1.2	K0353		
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 four 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 and readily identifiable. 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	K0918	In response to K0918: 1. PBJC has instituted a preventative maintenance schedule for the testing of emergency power source main and feeder circuit breakers. 2. A licensed electrical contractor will perform the required system testing as outlined by NFPA 110 & ANSI/NEMA AB4 standards. 3. The initial testing will be completed before 5/15/26 and based on the results of the inspection, a schedule of routine testing will be outlined (semi-annually or annually) and implemented for future scheduling. 4. The electrician will submit inspection results to the Director of Facilities and they will be added to the current logs. 5. This is assigned to the Director of Facilities to monitor and verify compliance.	

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K0918	Continued from page 3 facility failed to implement emergency power system inspection, testing, and maintenance requirements found in the 2012 Edition of 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 staff and patients in the event of electrical system failure during an emergency. The findings were: Document review on 04/13/2026 starting at 10:15 AM revealed the facility's emergency power systems were not tested and maintained in accordance with 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Health Care 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 had been established in accordance with the manufacturer's recommendations. Interview with the facility maintenance staff at the time of observation confirmed that documentation was not available. He also indicated that he was aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	K0918		
K0921 Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance	K0921		

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K0921 Bldg. 01	Continued from page 4 manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the Patient Care Related Electrical Equipment (PCREE) in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain PCREE could result in a failure of equipment, resulting in injury or death. The deficiency affected all PCREE within the facility, and could affect all patients that utilize the equipment. The findings were: Document review on 04/13/2026 starting at 9:45 AM revealed that no documentation was available at the time of the survey to demonstrate testing of PCREE equipment as required. The physical integrity, resistance, leakage current, and touch current tests shall be tested before equipment is put in to use, or annually, as necessary. Interview with the facility maintenance staff at the time of observation confirmed the deficiency, and confirmed that documentation was not readily available. Interview with the director of nursing at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 10.3	K0921	In response to K0921: 1. Agreement with vendor, HSS Security LLC., finalized 4/9/26. Vendor will provide PM service, labor, and testing on PCREE equipment quarterly, with the initial testing completed by 5/22/26. 2. This is assigned to the ASC Director to monitor and ensure compliance.	

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E0000	Initial Comments An Emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 04/13/2026. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		
E0004	Develop EP Plan, Review and Update Annually CFR(s): 416.54(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	In response to E0004: 1. The Emergency Preparedness Plan will be updated by 5/22/26, and annually thereafter. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will reported to the QAPI Committee annually.	

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	ASC Director	4-23-26

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E0004	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to maintain and update the Emergency Preparedness Plan (EPP) on an annual basis in accordance with 42 CFR 483.73. Failure to update the EPP as required could lead to out-of-date information and/or policies, which may inhibit the facility's ability to respond during an emergency, leading to injury or death. The findings were: Document review of the Emergency Preparedness Plan (EPP) on 04/13/2026 starting at 9:45 AM revealed that the plan had not been updated within the past 12 months. Review identified that updates had occurred in 2022 and 2024, but not in 2025. The EPP must be updated on an annual basis. Interview with the director of nursing at the time of the observation confirmed the deficiency, and indicated she was aware of the requirement. Interview with the director of nursing a the time of exit confirmed the deficiency.	E0004		
E0023	Policies/Procedures for Medical Documentation CFR(s): 416.54(b)(4) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(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,	E0023		

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E0023	Continued from page 2 the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to maintain policies and procedures for medical documents as a part of the Emergency Preparedness Plan. Failure to maintain policies as required could limit the facility's ability to preserve patient information, protect confidentiality, and maintain availability of records during an emergency. The findings were: Document review of the Emergency Preparedness Plan (EPP) on 04/13/2026 starting at 9:45 AM revealed that the facility could not provide policies and procedures regarding medical documentation. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was not aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0023	In response to E0023: 1. The Emergency Preparedness Plan will be updated to include policies and procedures regarding medical documentation, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	
0026	Roles Under a Waiver Declared by Secretary	E0026		

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E0026	Continued from page 3 CFR(s): 416.54(b)(6) §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 develop or maintain policies regarding the role of the facility under a waiver declared by the secretary. Failure to maintain these policies as required could inhibit the facility's response in accordance with Section 1135 of the Act, regarding provisions of care and treatment at an alternate care site as identified by emergency management officials. The findings were: Document review on 04/13/2026 starting at 9:45 AM of the Emergency Preparedness Plan revealed that no policy was available to demonstrate applicable procedures in accordance with an 1135 waiver as declared by the Secretary. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was unaware of the requirement.	E0026	In response to E0026: 1. The Emergency Preparedness Plan will be updated to include a policy regarding the role of the facility under a waiver declared by the secretary, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	

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E0026	Continued from page 4 Interview with the director of nursing at the time of exit confirmed the deficiency.	E0026		
E0030	Names and Contact Information CFR(s): 416.54(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.	E0030		

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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
E0030	Continued from page 5 *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53C0001006	A. BUILDING B. WING	04/13/2026

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E0030	Continued from page 6 (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain contact information as applicable to their Emergency Preparedness Plan (EPP). Failure to maintain EPP contact information may inhibit the facility's ability to communicate affectively during an emergency. The findings were: Document review on 04/13/2026 starting at 9:45 AM of the Emergency Preparedness Plan (EPP) revealed that the plan included contact information for staff, entities providing services under contract, and emergency officials, but did not include contact information for the patient's physicians. The facility was relying on the ability to Google this information as needed, but this process may not be available during an emergency. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0030	In response to E0030: 1. The Emergency Preparedness Plan will be updated to include contact information for patient's physicians, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	
0032	Primary/Alternate Means for Communication CFR(s): 416.54(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3),	E0032		

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E0032	Continued from page 7 §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain policies for primary and alternate communication methods. Failure to develop primary and alternate communication methods may inhibit the facility's ability to communicate with staff, state, tribal, regional, or local emergency management agencies during an emergency. The findings were: Document review on 04/13/2026 starting at 9:45 AM of the Emergency Preparedness Plan (EPP) revealed that the facility was unable to produce a policy or procedure demonstrating the development of a primary and alternate means of commination. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0032	In response to E0032: 1. The Emergency Preparedness Plan will be updated to include a policy or procedure for primary and alternate communication methods, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	
033	Methods for Sharing Information CFR(s): 416.54(c)(4)-(6)	E0033		

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E0033	Continued from page 8 §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to develop or maintain methods for sharing information as required. Failure to do so may	E0033	In response to E0033: 1. The Emergency Preparedness Plan will be updated to include a policy or procedure for sharing information and medical documentation with other health care providers, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	

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E0033	Continued from page 9 inhibit the facility's ability to share information and medical documentation for patients under their care with other providers as necessary during an emergency. The findings were: Document review on 04/13/2026 starting at 9:45 AM of the Emergency Preparedness Plan (EPP) revealed that the facility was unable to produce a plan demonstrating policies and procedures for sharing information and medical documentation with other health care providers. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was not aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0033		
E0034	Information on Occupancy/Needs CFR(s): 416.54(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the	E0034		

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E0034	Continued from page 10 Incident Command Center, or designee. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to develop or maintain policies and procedures for sharing information on occupancy and needs. Failure to develop these policies and procedures as required could inhibit the facility's ability to provide information concerning the facility's needs, and it's ability to provide assistance, to the authority having jurisdiction, emergency command center, or a designee during an emergency. The findings were: Document review on 04/13/2026 starting at 9:45 AM revealed the facility could not produce a policy or procedure for sharing information regarding the facility's needs, or their ability to provide assistance during an emergency. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated she was not aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0034	In response to E0034: 1. The Emergency Preparedness Plan will be updated to include a policy or procedure for sharing information on occupancy and needs, or our ability to provide assistance during an emergency, by 5/22/26. This is assigned to the ASC Director. 2. The Emergency Preparedness Plan will be reviewed and reported to the QAPI Committee annually.	
E0039	EP Testing Requirements CFR(s): 416.54(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible,	E0039		

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E0039	Continued from page 11 conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following	E0039		

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E0039	Continued from page 12 the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E0039		

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E0039	Continued from page 13 plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that: is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct	E0039		

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E0039	Continued from page 14 exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional	E0039		

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E0039	Continued from page 15 exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E0039		

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E0039	Continued from page 16 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53C0001006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Bone and Joint Ambulatory Surgical Center	1909 Vista Drive , Laramie, Wyoming, 82070

(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
E0039	Continued from page 17 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by:	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53C0001006	A. BUILDING B. WING	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0039	Continued from page 18 Based on document review and staff interview, the facility failed to maintain testing of the Emergency Preparedness Plan (EPP) as required. Failure to conduct exercises and testing as required could result in facility staff being unfamiliar with necessary procedures, and may inhibit the facility's ability to respond during an emergency. The findings were: Document review on 04/13/2026 starting at 9:45 AM of the Emergency Preparedness Plan (EPP) revealed that the facility had performed a tabletop exercise in March of 2024. Facilities must perform a full-scale community-based, or if unavailable a facility-based, exercise at least bi-annually. Additionally, facilities must perform a second exercise that may be an additional full-scale exercise, or tabletop exercise, during this same time period. Interview with the director of nursing at the time of observation confirmed the deficiency, and indicated that she was aware of the requirement. Interview with the director of nursing at the time of exit confirmed the deficiency.	E0039	In response to E0039: 1. Exercises to test the emergency plan will be performed annually, including community-based or facility-based exercises every 2 years. This is assigned to the ASC Director. 2. A mock disaster drill will be completed by 5/22/26.	