STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laramie Health and Rehabilitation	**503 S 18th St , 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 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 06/02/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, two-story building with a basement of Type V (111) and Type V (000) construction built in 1920, 1972, and 1993. Portions of the building have been identified as Type III construction, and have been addressed via an FSES for compliance. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 52 residents. The following deficiencies demonstrate noncompliance with 42 CFR 483.90.	K0000		07/10/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K0222	Dining room and laundry corridor doors adjusted to unlock when delayed egress system is initiated. The Maintenance Director or designee will complete an audit of delayed egress doors to validate doors unlock when the delayed egress system is initiated. The Maintenance Director or designee was educated to validate delayed egress doors unlock when the delayed egress system is initiated. The Maintenance Director or designee will complete an audit of delayed egress doors to validate delayed egress doors unlock when the delayed egress system is initiated. The Maintenance Director or designee will report the	07/10/2026

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

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K0222 SS = E Bldg. 01	Continued from page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress components in accordance with NFPA 101, Life Safety Code. Failure to maintain egress components as required could lead to	K0222	Continued from page 1 tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026

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K0222 SS = E Bldg. 01	Continued from page 2 delayed egress of staff, residents, and visitors, which may result in injury or death. The deficiency affected multiple egress doors in the facility. The findings were: Observation on 06/02/2026 starting at 10:41 AM in the dining room revealed an exit discharge door that was of the delayed-egress type. Further observation revealed that when tested, the delayed egress system failed to initiate the irreversible process to unlock the door. Further observation at 11:22 AM of the laundry corridor exit revealed that the exit was provided with a wander guard system that locked the door when approached by a resident assigned to the system. The exit was provided with a delayed-egress system, but the system failed to initiate an irreversible process to unlock the door once initiated. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated that he was aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, Sec. 19.2.2.2.4(2), 7.2.1.6.1.1 (3)	K0222		07/10/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K0321	Rooms 227, 226, 231, and 232 cleared of storage. Self-closing device added to the Soiled Linen closet. The Maintenance Director or designee will complete an audit of rooms and closets to validate Self-closing devices are added to storage room doors. The Maintenance Director or designee was educated to validate rooms and closets used for storage have Self-closing devices. The Maintenance Director or designee will complete a weekly audit of rooms and closets to validate Self-closing devices are added to storage room doors. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026

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K0321 SS = E Bldg. 01	Continued from page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain hazardous areas as required could result in injury or death due to fire spread. The deficiency affected four (4) of numerous hazardous areas in the facility. The findings were: Observation on 06/02/2026 starting at 10:46 AM revealed several resident rooms that were being utilized for storage of large amounts of combustible materials. The rooms were provided with sprinkler coverage, but the doors were not provided with a self- or automatic-closing device. These conditions were observed in resident rooms 227, 226, 231, and 232. Additional observation on 06/02/2026 at 9:18 AM of the soiled linen closet located across from the administration office revealed that the self-closing device had been removed from the door. Interview with the facility maintenance manager at the time of each observation acknowledged the deficiencies, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiencies. REF: 2012 NFPA 101, Sections 19.3.2.1 and 19.3.2.1.3.	K0321		07/10/2026

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K0200 SS = D Bldg. 01	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain door leaf encroachment within the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain door leaf encroachment as required could result in the delay of occupant egress during an emergency, which could result in injury or death. The deficiency affected one (1) of multiple doors swinging into the corridors throughout the facility. The findings were: Observation on 06/02/2026 at 10:21 AM of the dry storage closet across from the generator room revealed the door opened into the corridor and was prevented from opening fully by the self-closing device. The door opened to approximately 90 degrees. Doors swinging into the corridor must swing to a maximum encroachment of 7.5 inches into the corridor to minimize obstructions to the means of egress. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.4.3.1	K0200	"Past Noncompliance - no plan of correction required"	07/10/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K0324	Gas Cooktop placed beneath the grease hood and fire suppression system. The FANS Manager or designee will validate the guides intended to properly locate the stove are in good repair. The FANS Manager or designee educated kitchen	07/10/2026

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K0324 SS = D Bldg. 01	Continued from page 5 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect cooking equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were: Observation on 06/02/2026 at 10:32 AM in the kitchen revealed a wheeled gas-fired cooktop located beneath the grease hood and fire suppression system. Further observation revealed that a means was provided to ensure that the cooktop is returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Further observation revealed that the cooktop had not been placed back within the guides intended to properly locate the equipment. As a result, the cooktop was partially located outside of the grease hood and suppression system. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K0324	Continued from page 5 staff to validate the stovetop is placed beneath the grease hood and fire suppression system. The FANS Manager or designee will complete a weekly audit to validate the stovetop is placed beneath the grease hood and fire suppression system. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026

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K0324 SS = D Bldg. 01	Continued from page 6 REF: 2012 NFPA 101, Sections 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K0324		07/10/2026
K0345 SS = D Bldg. 01	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 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain portions of the fire alarm system as required per the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the system as required could result in malfunction during an emergency, which could result in injury or death. The deficiency could impact all staff, residents, and visitors within the facility. The findings were: Document review on 06/02/2026 starting at 1:00 PM of the fire drill and fire alarm testing documents revealed that the facility had duplicated 3rd shift fire drills during the month of September, 2025. As a result, the fire alarm was not activated during the drills, and not provided with a monthly activation as required. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency. REF: NFPA 72, Table 14.4.5(24)	K0345	Facility Maintenance Manager confirmed the requirement of the monthly activation of the fire alarm system. The Maintenance Manager confirmed the requirement for the monthly activation of the fire alarm system. The Administrator or designee educated the Maintenance Manager to validate the monthly activation of the fire alarm system. The Maintenance Manager or designee will complete a weekly audit to validate the monthly activation of the fire alarm system for compliance. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K0918	Main and feeder circuit breakers were inspected The Maintenance Manager confirmed the requirement for the annual Main and feeder circuit breakers inspection.	07/10/2026

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K0918 SS = D Bldg. 01	Continued from page 7 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to maintain main and feeder circuit breakers in accordance with 2012 NFPA 99, Heath Care Facilities Code. Failure to maintain main and feeder circuit breakers as required could result in faulty or inoperable equipment. The deficiency affected the facilities main and backup electric system. The findings were: Document review on 06/02/2026 starting at 1:00 PM revealed the facility did have an established program for inspecting and exercising electrical components in accordance with manufacturer's recommendations, but that testing had not been performed within the past 12 months. Main and feeder circuit breakers shall be inspected annually. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated that he was aware of the requirement. Interview with the facility administrator at the time of	K0918	Continued from page 7 The Administrator or designee educated the Maintenance Manager to validate the annual inspection of the Main and feeder circuit breakers. The Maintenance Manager or designee will add the annual requirement for the inspection of the Main and feeder circuit breakers to their Preventive Maintenance log. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026

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K0918 SS = D Bldg. 01	Continued from page 8 exit confirmed the deficiency. REF: 2012 NFPA 99 6.4.4.1.2	K0918		07/10/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 06/02/2026. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		07/10/2026
E0031 SS = F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	E0031	Emergency Management plan updated to include contact information for state, trial, regional, or local emergency officials. The Maintenance Director or designee will review the Emergency Management plan to validate contact information for state, trial, regional, or local emergency officials have been updated. The Maintenance Director or designee will review monthly the Emergency Management plan to validate contact information for state, trial, regional, or local emergency officials have been updated. The Maintenance Director or designee was educated to validate the Emergency Management plan included contact information for state, trial, regional, or local emergency officials. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026

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Laramie Health and Rehabilitation	**503 S 18th St , Laramie, Wyoming, 82070**

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E0031 SS = F	Continued from page 1 *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is NOT MET as evidenced by: Based on Document review and Staff interview, the facility failed to provided emergency contact information as a part of their Emergency Communication Plan as required. Failure to include this information may delay contact with State, tribal, regional, or local emergency officials, which may lead to injury or death during an emergency. The findings were: Review of the Emergency Preparedness plan on 06/02/2026 starting at 1:00 PM revealed that the communication plan did not include contact information for State, tribal, or local emergency staff. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	E0031		07/10/2026
E0032 SS = F	Primary/Alternate Means for Communication CFR(s): 483.73(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), §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:	E0032	Emergency Management plan updated to include procedures for establishing a method to contact emergency officials outside of the facility. The Maintenance Director or designee will review the Emergency Management plan to validate procedures for establishing a method to contact emergency officials outside of the facility are updated. The Maintenance Director or designee will review monthly the Emergency Management plan to validate procedures for establishing a method to contact emergency officials outside of the facility are updated. The Maintenance Director or designee was educated	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laramie Health and Rehabilitation	**503 S 18th St , 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
E0032 SS = F	Continued from page 2 (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 REQUIREMENT is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to establish a means of primary and alternate means of communication as a part of their Emergency Preparedness Plan. Failure to develop a means of alternate communication may inhibit the facility's ability to contact emergency officials outside of the facility during and emergency, and may result in injury or death. The finding were: Review of the facility's Emergency plan on 06/02/2026 starting at 1:00 PM revealed the plan did not include a policy or procedure for establishing a method to contact emergency officials outside of the facility. All means of communication were via hardline or cell phone, which have a high likelihood of failure during an emergency. Staff are provided with walkie-talkies for internal communication, but no plans were in place to facilitate communication to outside entities. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the facility administrator at the time of exit confirmed the deficiency.	E0032	Continued from page 2 to validate the Emergency Management plan is updated to include procedures for establishing a method to contact emergency officials outside of the facility. The Maintenance Director or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	07/10/2026