STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Casper	**4041 South Poplar St , Casper, Wyoming, 82601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 07/14/2026 and 7/15/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 (a) except as otherwise provided in the Section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch, and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 69 residents.	K0000		08/06/2026
K0345 SS = F 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 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 all residents, staff, and visitors at the facility. The findings were:	K0345	K0345- Problem Statement-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 system evidenced by facility failed to provide documentation of testing and maintenance of the fire alarm system as evidenced by no documentation of smoke detector sensitivity test. Corrective action-education to Maintenance Director and assistant related to failure to provide documentation of testing and maintenance of the fire alarm system in accordance with 2010 NFPA 72, and 2012 NFPA 101, Life Safety Code by 8/11/2026. Identification of others-Failure to test and maintain fire alarm, and failure to provide documentation of the smoke detector sensitivity test, in accordance of the 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	08/11/2026

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

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K0345 SS = F Bldg. 01	Continued from page 1 Document review on 07/15/2026 starting at 8:30 AM 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) Smoke Detector sensitivity test - Table 14.4.5(15)(i) Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.6.3.1, 9.6.1.5 2010 NFPA 72, Table 14.4.5	K0345	Continued from page 1 in injury or death in the event of a fire to staff, residents, and visitors at the facility. Systemic changes-Maintenance Director/Designee will have Smoke Detector Sensitivity test completed and placed into TELS with a copy sent to ED after every inspection of the Fire Alarm System. On-going monitoring-Maintenance Director/designee will complete Smoke Sensitivity Test as directed by 2012 NFPA 101, Life Safety Code and 2010 NFPA 72, National Fire Alarm and Signaling Code and to Discuss in QAPI monthly or until substantial compliance is achieved.	08/11/2026
K0355 SS = F Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and inspect portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to properly test and inspect portable fire extinguishers could result in injury or death in the event of a fire emergency. The deficiency affected all portable fire extinhuishers throughout the facility. The findings were: Document review on 07/15/2026 starting at 8:30 AM revealed that no records were available to demonstrate that all required monthly inspections had been performed as required. Review of inspection tags located at each fire extinguisher revealed that monthly inspections had been performed, but that no tags or records were available to confirm inspections since the last annual inspection. Interview with the facility manager at time of observation acknowledged the deficiency, and	K0355	K0355 Problem Statement-Facility failed to test and inspect portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 10, Standard for portable Fire Extinguishers. Revealed by no records were available to demonstrate that all required monthly inspections had been preformed as required. Review of inspection tags located at each fire extinguisher revealed monthly inspections but no tags or records were available to confirm inspections since last annual inspection. Corrective actions-Maintenance Director and assistant will receive education to the fact that all tags on each fire extinguisher will be maintained from one yearly survey to the next yearly survey in accordance with 2012 NFPA 101, Life Safety Code and 2010 NFPA 10, Standard for Portable Fire Extinguishers. All portable fire extinguishers will have tags kept attached until the following Annual Survey. 100% audit of Portable Fire Extinguishers will be completed to ensure all tags are attached and filled out proper by 8/11/2026. Identification of others-All portable fire extinguishers were without tags from last annual survey to current annual survey. Systemic Changes-Maintenance Director/designee will assure that all tags are attached to portable Fire extinguishers until the following Annual Survey, and	08/11/2026

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K0355 SS = F Bldg. 01	Continued from page 2 indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: NFPA 10, Sections 7.2.1.2	K0355	Continued from page 2 logged into Tels when monthly inspections are completed that Tags are still attached. On-going monitoring-Maintenance Director/designee will complete audits monthly x3 or until substantial compliance is met and will discuss findings in QAPI monthly.	08/11/2026
K0521 SS = F Bldg. 01	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 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 07/14/2026 starting at 8:30 AM 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 manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged 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	K0521 Problem Statement-Facility failed to test fire dampers in accordance with the 2012 NFPA 101, Life Safety Code: 2012 NFPA 90 A Standard for Installation of Air-Conditioning and Ventilating Systems: 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Revealed by facility failed to ensure fire dampers were inspected and maintained every 4 years. Corrective Actions-Maintenance Director and Assistant will be educated on the need for dampers to be inspected every 4 years in accordance with 2010 NFPA 80 and will be monitored via TELS. Dampers were inspected on 7/21/2026 by Fire and Life Safety Company. Identification of others-Failure to inspect and maintain fire dampers could result in injury or death in the event of a fire. Systemic Change-Maintenance Director/designee will ensure that Fire Dampers are monitored every 4 years by a Fire and Life Safety Company and Placed in TELS if not already in the system. On-going monitoring-Maintenance Director will get inspection of dampers completed and it will be placed TELS as a every 4 year test to be completed.	08/11/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K0918	K0918 Problem statement-The facility failed to ensure essential electrical systems were tested and maintained in accordance with the 2012 NFPA 99,	08/11/2026

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K0918 SS = F Bldg. 01	Continued from page 3 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 ensure essential electrical systems were tested and maintained in accordance with the 2012 NFPA 99, Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to test and maintain essential electrical systems could result in injury or death in the event of failure. The deficiencies could impact all patients, staff, and visitors. The findings were: Document review on 07/15/2026 starting at 8:30 AM revealed the facility failed to provide documentation of Level 1 EPSS 4 hour testing every 36 months. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency.	K0918	Continued from page 3 Healthcare Facilities Code, and the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. On 7/15/2026 facility failed to show documentation for Level 1 EPSS 4 hour testing every 36 months. Corrective Actions-Maintenance Director and assistant will receive education on the need for 4-hour generator test every 36 months and documentation in TELS. The 4 hour generator test will be completed by 8/11/2026. Identification of others-Failure to test and maintain essential electrical systems could result in injury or death in the event of failure. The deficiencies could impact all community members, staff, and visitors. Systemic Changes-Maintenance Director/designee will assure that 4 hour generator test are completed every 36 months by placing into TELS. On-going monitoring-Maintenance Director will enter the next 4 hour generator test into TELS for 35 months to give adequate time for TWE to perform 4 hour test.	08/11/2026

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K0918 SS = F Bldg. 01	Continued from page 4 REF: 2012 NFPA 99, Sections: 6.4.4.1.2, 6.4.4.1.1.3 2010 NFPA 110, Sections: 8.4.9	K0918		08/11/2026
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 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	K0321	K0321 Problem Statement-Facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code evidenced by the following: fire sprinkler room revealed penetrations for piping in the fire rated walls and ceiling that were not approved fire-stop system. In the boiler room revealed that the fire-rated wall had a section removed from the dry wall. This deficiency could delay egress resulting in injury or death in an emergency. Corrective action-education to Maintenance Director and assistant, and Maintenance Director/designee will have area in the fire sprinkler room and boiler room corrected by 8/11/2026. Identification of others-Failure to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Codes could delay egress resulting in injury or death during an emergency. Systemic changes-Maintenance Director or designee will do a 100% audit of all hazardous areas, then do monthly audits x 3 months and then quarterly. On-going monitoring-Maintenance Director/designee will complete audits to monitor hazardous area in accordance with 2012 NFPA 101, Life Safety Code, audits will be brought to QAPI meeting x 3 months or until substantial compliance is achieved.	08/11/2026

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K0321 SS = E Bldg. 01	Continued from page 5 with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous rooms in the facility. The findings were: Observation on 07/14/2026 at 1:20 PM in the fire sprinkler room, revealed penetrations for piping in the fire-rated walls and ceiling that were not protected with an approved fire-stop system. Observation on 07/14/2026 at 1:25 PM in the boiler room, revealed that the fire-rated wall had a section removed from the dry wall. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Sections 19.3.2; 8.7.1; 8.3.1.2; 8.3.5.1	K0321		08/11/2026
K0100 SS = D Bldg. 01	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain obvious equipped safety features in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain obvious equipped safety features as required could result in injury or death due in an emergency. The deficiency affected one (1) smoke compartments in the facility. The findings were: Observation on 07/01/2026 at 3:09 PM at the activities room doors revealed that the existing 20 minute fire-rated doors contained visible holes as a result of the fire-door hardware replacement. The integrity of fire-rated doors must be maintained at all times to ensure proper fire and smoke compartmentalization.	K0100	K0100 Problem Statement-Facility Failed to maintain obvious equipped safety features in accordance with the 2012 NFPA 101, Life Safety Code. Standard not met by observation of activities room doors revealed that the existing 20 min fire rated doors contained visible holes as a result of the fire-door hardware replacement. Corrective actions-Education to Maintenance Director and assistant regarding holes in 20 minute rated fire doors in accordance to 2012 NFPA 101, Life Safety Code. 100% audit to be completed by of all 20 min rated fire doors with repairs by 8/11/2026. The failure to maintain obvious equipped safety features as required could result in injury or death in an emergency. Systemic changes-Maintenance Director/designee will assure that all 20 min fire doors are inspected and repaired monthly, and documented in TELS. Ongoing monitoring-The Maintenance Director will ensure that all 20-min fire doors are in accordance	08/11/2026

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K0100 SS = D Bldg. 01	Continued from page 6 Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.3	K0100	Continued from page 6 with 2012 NFPA 101, Life Safety Code audits will be brought to QAPI x 3 months or until substantial compliance is achieved.	08/11/2026
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 egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous doors. The findings were: Observation on 07/14/2026 at 12:45 AM at the #2 social services/office exit, revealed that when tested the force applied to open the door was measured to be in excess of 30 lbf. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5.1	K0200	K0200-Means of Egress- The facility failed to maintain egress doors in accordance with 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. Corrective action-education provided to Maintenance Director and Maintenance assistant by 8/3/2026. Identification of others-the deficiency affected one of numerous doors which is labeled #2 by social services office. Systemic changes- Maintenance Director will get equipment needed to complete testing on egress doors to maintain 15lbs of pressure to open egress door. 100 percent audit of all egress doors will be completed by 8/11/2026. Ongoing monitoring-The Maintenance Director or designee will ensure that all egress doors will be tested and documented weekly for force applied in accordance with 2012 NFPA 101, Life Safety Code. Audit in TELS will be brought to QAPI meeting for 3 months or until substantial compliance.	08/11/2026
K0271 SS = D Bldg. 01	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7,	K0271	K0271- Facility failed to provide an exit discharge that provides a level walking surface meeting the 2012 NFPA 101, Life Safety Code with respect to abrupt changes in walking surfaces in the means of egress.	08/11/2026

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K0271 SS = D Bldg. 01	Continued from page 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, which could result in injury or death during an emergency. The deficiency affected one (1) of multiple exits. The deficiency could affect all residents, staff, and visitors. The findings were: Observation on 07/14/2026 at 1:55 PM revealed the exit path from the med records exit to the public way included a concrete walking surface with an abrupt change in elevation of walking surface. 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 manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.6	K0271	Continued from page 7 Corrective action-education to Maintenance Director and assistant to monitor all means of egress and have corrected by Final Impressions, they will be doing a 1 foot x 3 foot section of sidewalk by Medical Records exit, it will be filled and tapered and broom brushed, with a waterproof sealer to be applied to concrete overlay after it is dried. Identification of others-Failure to provide a level of means of egress as required by 2012 NFPA 101, Life Safety Code could delay egress resulting in injury or death during an emergency. Systemic changes-Maintenance Director/designee will complete monthly audits on all means of egress monthly x 3 months and then quarterly. On-going monitoring- Maintenance Director/designee will complete audits to monitor means of egress, audits will be brought to QAPI meeting reviewed x 3 months or until substantial compliance is achieved.	08/11/2026
K0351 SS = D Bldg. 01	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	K0351	K0351 Problem Statement-Facility failed to maintain the fire sprinkler system in accordance with 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13 Standard for the Installation of Sprinklers as evidenced by room 225 bathroom sprinkler was missing its escutcheon which exposed the annular space above the ceiling. Corrective action-Education given to Maintenance Director and assistant related to room 225 bathroom missing its escutcheon which is exposing the annular space above the ceiling, in accordance with 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13 Standard for the Installation of Sprinklers.	08/11/2026

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K0351 SS = D Bldg. 01	Continued from page 8 local regulations prohibit sprinklers. 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 maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency affected one (1) of numerous sprinkler heads throughout the facility. The findings were: Observation on 7/14/2026 at 3:38 PM in the bathroom for room 225, revealed that the sprinkler head was missing its escutcheon, which exposed the annular space above the ceiling. Failure to protect openings at sprinklers may result in reduce reaction time during a fire event, and may result in fire spread to the exposed areas. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101: Section 19.3.5.1, 9.7.1.1(1) 2010 NFPA 13: Section 6.2.7.1	K0351	Continued from page 8 Sprinkler head will have the needed escutcheon by 8/11/2025. Identification of others-Failure to protect openings at sprinklers may result in reduce reaction time during a fire event, and may result in fire spread to the exposed areas which could result in injury or death . Systemic changes-Maintenance Director/Designee will complete a 100% audit of all sprinkler heads to make sure they are in accordance with 2012 NFPA 101, Life Safety Code and the 2010 NFPA 13 Standard. On-going monitoring- Maintenance Director/designee will complete audits x 3 months or until substantial compliance is achieved and brought to QAPI meeting or until substantial compliance is achieved.	08/11/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance	K0761	K0761- Problem Statement-Facility failed to ensure that doors had appropriate hardware in accordance with 2012NFPA 101, Life Safety Code. Failure to ensure that the Fire Rated doors are equipped correctly with rated hardware as required. Evidenced by breakroom storage door revealed that the fire rated door was missing the door latch. Corrective action-Maintenance Director and assistant	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0761 SS = D Bldg. 01	Continued from page 9 program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that doors had appropriate hardware in accordance with 2012 NFPA 101, Life Safety Code. Failure to ensure that fire-rated doors are equipped with correctly rated hardware as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous door hardware sets in the building. The findings were: Observation on 7/14/2026 at 1:44 PM at the breakroom/storage door revealed that the fire-rated door was missing the door latch.Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 101 Sections 7.2.1.5.10, 19.2.2.2.1	K0761	Continued from page 9 will receive education to the need of all fire rated doors are equipped with correctly rated hardware as required in accordance with and 2012 NFPA 101, Life Safety Code. Hardware to the breakroom door will be repaired by 8/11/2026. Identification of others-Failure to ensure that the fire rated doors are equipped with correctly rated hardware as required could result in injury or death during an emergency. Systemic changes-Maintenance Director/Designee will complete 100% audit on all fire rated doors for appropriate hardware in accordance with 2012 NFPA 101, Life Safety Code. On-going monitoring-Maintenance Director /designee will complete audits monthly x 3 months or until substantial compliance is achieved and reported in QAPI monthly.	08/11/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible	K0923	K0923 Problem Statement-Facility failed to store helium in accordance with the 2012 NFPA 99, Health Care Facility Codes. Standard not met by observation in the activities office revealed one small tank of helium not secured. Corrective action-Education to Activities Director regarding safe placement of helium tank in accordance with 2012 NFPA 99, Health Care Facility Code. Small helium tank was taking to proper storage area on 7/14/2026. Identification of others-The failure to store helium as required may result in injury or death for community members, staff or family.	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/15/2026**

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K0923 SS = D Bldg. 01	Continued from page 10 construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store helium in accordance with the 2012 NFPA 99, Health Care Facilities Code. The failure to store helium as required may result in injury or death. The deficiency affected one (1) room out of numerous rooms in the facility. The findings were: Observation on 07/14/2026 at 3:00 PM in the activities office revealed one (1) small tank of of helium gas that was unsecured. Interview with the facility manager at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2012 NFPA 99: Sections 11.3.2.6, 11.6.2.3(11)	K0923	Continued from page 10 Systemic Changes-Activities Director will ensure that helium bottle is stored in proper storage area and not left in office after use. Ongoing monitoring-The Activities Director will ensure that Helium tank is stored in proper area and not left in office by completely weekly audit x 1 month, and then monthly audits x 2 months. Audits will be brought to QAPI x 3 months or until substantial compliance is achieved.	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 07/14/2026 and 07/15/2026. Based on the findings of the survey, the facility was in compliance with the requirements of 42 CFR 483.73	E0000		08/06/2026

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