STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	**1000 S DOUGLAS HWY** **GILLETTE, WY 82716**

(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
K 000	INITIAL COMMENTS Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (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, two story building with a basement of Type II (111) built in 2016. The building was equipped with a supervised automatic wet and dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 160 certified Medicare and Medicaid beds with a census of 148 residents.	K 000		
K 222 SS=E	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 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		12/3/17

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

Electronically Signed — 11/10/2017

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 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.

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K 222	Continued From page 1 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	K 222		

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K 222	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exits in accordance with 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 10/18/2017 at 12:35 PM at the 2nd floor South exit revealed delayed egress signage was not provided to describe delayed egress operation. Further observation at the South Pine Place exit also revealed delayed egress operation signage missing. Failure to post signage could delay egress through exit doors which could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation revealed awareness of the requirement REF: 2012 NFPA 101 Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4) 2. Observation on 10/18/2017 at 10:36 AM at the 2nd floor stairwell 3 revealed that the delayed egress door once released could be locked automatically with an employee badge instead of only being able to be locked manually. Interview with the Administrator indicated that all delayed egress doors operated the same way. Failure to maintain exits as required could result in delayed egress resulting in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(3)(d)	K 222	Correction for cited residents/environment: 2nd floor South Exit and Pine Exit delayed egress signage applied to door to describe delayed egress operation. 2nd floor stairwell, 3 reprogrammed to be reset manually delayed egress doors. Identification of other residents: All residents/staff have the potential to be affected by non-marked locking egress doors. Systematic changes and Monitoring: 1. Safety Officer or designee to conduct annual safety sweep of all egress doors for signage and functioning per regulation. 2. Incorporate inspection of egress doors for appropriate functioning and signage during fire drills. 3. Staff education related to egress signage and manual reset of egress doors. 4. All other stairwell exit doors reprogrammed to be reset manually to ensure maintenance of exits as required by regulation. Outcome: 1. All delayed egress doors will have signage as well as be reset manually after activation. 2. Safety Officer or designee will conduct annual survey of delayed egress stairwells and doors. Data will be aggregated on Environment of Care dashboard and	

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K 222	Continued From page 3	K 222	reported annually with action plans as appropriate.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain self closing doors in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 10/18/2017 at 9:22 AM outside room 20 revealed that the self closing doors did not latch. Further observation revealed that the self closing doors in rooms 30, 37 and throughout the facility failed to properly latch. Failure to maintain self closing doors as required could result in smoke spread resulting in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement.	K 223	Correction for Cited residents/environment: Self Closing doors in room 20, 30, 37 adjusted to properly latch. Identification of other residents: All residents/staff have the potential to be affected by non-self-closing doors resulting in smoke spread resulting in injury or death during an emergency. Systematic changes and Monitoring: 1. Safety Officer or designee to conduct quarterly inspection of all self closing doors in facility. 2. Staff education to all staff to complete	12/3/17

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K 223	Continued From page 4 REF: 2012 NFPA 101 Section: 19.3.2	K 223	work orders for malfunctioning and self latching doors. 3. Electronic preventive work order created for quarterly inspections. 4. Audit to be completed on all doors with self closing devices to be completed and deficiencies corrected. Outcome: 1. All hazardous areas will have self-closing doors. 2. Safety Officer or designee will conduct quarterly survey of hazardous areas to determine self-closing doors are installed and functioning. Data will be aggregated on Environment of Care dashboard and reported quarterly with action plan as appropriate.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting in accordance with 2010 NFPA 110, Emergency and Standby Power. The findings were; Observation on 10/18/2017 at 9:00 AM in the emergency generator transfer switch room revealed no battery powered emergency lighting was provided. In an emergency where the transfer switch failed to operate the battery powered emergency lighting would provide	K 291	Correction for cited residents: Battery powered emergency lighting to be installed in emergency generator transfer switch room to provide illumination of the transfer switch. Identification of other residents: All residents have the potential to be affected by inadequate illumination of the emergency generator transfer switch.	12/3/17

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K 291	Continued From page 5 illumination at the transfer switch. Interview with the Facility Maintenance Manager at the time of observation revealed he was aware of the requirement. REF: 2010 NFPA 110 Section: 7.3.1	K 291	Systematic changes and Monitoring: 1. Safety Officer or designee will conduct Emergency Lighting Audit annually to ensure all emergency lighting regulations as well as automatic and battery functioning is met per standard. 2. Electronic PM work order created to complete audits. 3. Staff education regarding emergency lighting requirements. Outcome: 1. All Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with NFPA 110 2010. 2. Safety Officer or designee will conduct annual audit of all emergency lighting locations for regulation compliance. Data will be aggregated on Environment of Care dashboard and reported annually with action plans as appropriate.	
K 923 SS=D	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 construction having a minimum	K 923		12/3/17

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K 923	Continued From page 6 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen tanks in accordance with 2012 NFPA 99, Health Care Facilities. The findings were: Observation on 10/18/2017 at 1:04 PM in room 237F revealed that oxygen tanks were stored within 5 feet of combustibles. Further observation in oxygen storage rooms 129G, and 145F also revealed combustibles within 5 feet of oxygen tanks. Failure to store oxygen tanks as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of the observation revealed that he was aware of the	K 923	Correction for cited residents: Trash cans removed from oxygen storage locations in room 237F, 129G, and 145F. Signage placed in all oxygen rooms regarding storage of oxygen and combustible requirement. Identification of other residents: All residents have the potential to be affected by the inappropriate storage of combustibles in same location as oxygen containers. Systematic changes and Monitoring: 1. Staff education regarding storage of	

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K 923	Continued From page 7 requirement. REF: 2012 NFPA 99: Section: 11.6.2.1	K 923	oxygen and combustibles. 2. Signage placed in all oxygen storage areas regarding combustibles and oxygen storage. 3. Policy regarding oxygen storage reviewed and revised to include combustibles and oxygen storage. Outcome: 1. All oxygen storage areas will have no combustible storage items in the storage area. 2. Safety Officer or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported quarterly at Safety Committee with action plan as appropriate.	