STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING 01 B. WING _____	10/24/2018

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 23-24, 2018. 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 152 residents.	K 000		
K 321 SS=D	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.	K 321		12/9/18

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

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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 321	Continued From page 1 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide protection for hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide protection as required could result in injury or death during an emergency. The deficiency affected one of numerous doors in the facility, as well as the 450 residents and staff. The findings were: Observation on 10/23/2018 at 12:16 PM in room 023 (medical storage) revealed a storage room that was greater than 50 square feet, and which contained combustible material deeming the room as hazardous. Further observation revealed that the self-closing door failed to close. Interview with the facility maintenance manager at the time of observation acknowledged the door failed to close, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 321	Correction for cited environment: 1. Door in room 023 (medical storage) was corrected on 10/23/18 to assure that the self-closing mechanism was operating as intended. Identification of other environments: All residents/staff have the potential to be affected by failure to provide protection for hazardous areas in accordance with 2012 NFPA 101, Life Safety code. Systematic changes and monitoring: Quarterly audit of fire doors to be completed by plant operations. Education per plant operations on importance of protection of hazardous areas, as it relates to self-closing door mechanism at all staff meeting on 11/8/18. Outcome: 100% of self-closing doors that enclose hazardous areas shall be self-closing or	

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K 321	Continued From page 2 REF: 2012 NFPA 101, Section: 19.3.2.1.3 .	K 321	automatic closing as measured by audits completed by plant ops or designee on a quarterly basis. Data will be aggregated and reported quarterly at long term care quality meetings and discrepancies investigated and reported.	
K 345 SS=E	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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to maintain fire alarm systems as required could result in injury or death during an emergency. The deficiencies affected 1 of the 3 major alarm (Initiating, Supervisory, and Notification) testing requirements, as well as the 450 residents and staff. The findings were: Document review on 10/24/2018 at 9:00 AM revealed that the facility was unable to verify the listing of all notification device locations per the approved layout, and the facility could not verify that the devices had been tested.	K 345	Correction for cited environment: Verified on 10/26/18 that all device locations per approved layout were tested but documentation was not on site for review. Unable to correct at time of survey. Identification of other environments: All residents/staff have the potential to be affected by failure to show documentation of the initiating, supervisory, and notification of the fire alarm system. Systematic changes and monitoring: Licensed contractor scheduled to complete fire alarm testing January 2019. Waiver application to be completed by December 9th, 2018.	12/9/18

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K 345	Continued From page 3 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 acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.4.1; 9.6.1.5 2010 NFPA 72, Sections: 14.6.2.4; Table 14.4.2.2(27)(g) .	K 345	Education on importance of fire system testing at all staff meeting on 11/8/18. Outcome: 100% of fire alarm and signaling code will show testing records of system acceptance, maintenance, and testing is readily available within the facility. Data will be collected by plant operations (or designee) and will be aggregated and reported annually at long term care quality meetings. All discrepancies will be investigated and reported.	
K 353 SS=D	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 _____ 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 353	Correction for cited environment:	12/9/18

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K 353	Continued From page 4 facility failed to perform sprinkler maintenance in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected 2 of numerous sprinkler heads, as well as the 450 residents and staff. The findings were: Observation on 10/23/2018 at 12:18 PM in room 016 revealed that the escutcheon around the sprinkler head was missing. Further observation revealed a second missing escutcheon in room 005. Interview with the facility maintenance manager at the time of observation acknowledged the missing escutcheons, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.3; 9.7.5 2010 NFPA 13, Section: 6.2.7 .	K 353	1. Escutcheon around sprinkler head installed on 10/23/18 in room 016 as well as in room 005. Identification of other environments: All residents/staff have the potential to be affected by failure to maintain sprinkler systems as required. Systematic changes and monitoring: -Revision of leadership rounds form to include the auditing of sprinkler heads and proper escutcheon location. -Education on importance of fire sprinkler maintenance at all staff meeting on 11/8/18. Outcome: 100% of sprinkler heads will be have escutcheons to maintain the sprinkler system as measured by leadership rounds. Data will be collected by plant operations (or designee) and will be aggregated and reported annually at long term care quality meetings. All discrepancies will be investigated and reported.	
K 355 SS=D	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 REQUIREMENT is not met as evidenced by:	K 355		12/9/18

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K 355	Continued From page 5 Based on observation and staff interview, the facility failed to maintain 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 maintain portable fire extinguishers as required could result in injury or death during an emergency. The deficiency affected 2 of numerous portable fire extinguishers in the facility, as well as the 450 residents and staff. The findings were: Observation on 10/23/2018 at 11:56 AM revealed a portable fire extinguishers adjacent to room 033 that had not been inspected during the month of September 2018. Further observation revealed a second portable fire extinguisher adjacent to room 2309 that was not inspected during September 2018. Interview with the facility maintenance manager at the time of observation acknowledged the portable fire extinguishers had not been signed off in September, and indicated he was aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.12; 9.7.4.1 2010 NFPA 10, Section: 7.2.1.2	K 355	Correction for cited environment: 1. Fire extinguisher check completed on 10/23/18 on portable devices located outside room 033 and room 2309. Identification of other environments: All residents/staff have the potential to be affected by failure to check fire extinguishers monthly for proper functioning. Systematic changes and monitoring: - Education on importance of checking fire extinguishers at all staff meeting on 11/81/18. - Floor plan of facility marked with fire extinguisher location and will be checked monthly utilizing audit tool. Outcome: 100% of fire extinguishers will be inspected and maintained in accordance with NFPA 10 on a monthly basis. Data will be collected by plant operations (or designee) and will be aggregated and reported at monthly long term care meetings. All discrepancies will be investigated and reported.	
K 711 SS=E	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all	K 711		12/9/18

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K 711	Continued From page 6 patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a fire plan in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a fire plan as required could result in injury or death during an emergency. The deficiency affected 100 percent of the facility, as well as the 450 residents and staff. The findings were: Document review on 10/24/2018 at 9:20 AM revealed that the fire plan did not provide for evacuation of smoke compartments as required. The fire plan did not clearly state moving residents through the smoke/fire doors into the adjacent smoke compartment. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.1.1;	K 711	Correction for cited environment: 1. Patient Evacuation and Shelter-In-Place policy was corrected on 10/30/18 and sent to environment of care committee for approval on 11/15/18. Policy was approved at emergency preparedness committee on 11/13/18. Identification of other residents: All residents/staff have the potential to be affected by not having a fire plan with evacuation of smoke compartments as required. The fire plan did not clearly state moving residents through the smoke/fire doors into the adjacent smoke compartment. Systematic changes and monitoring: - Education on importance of fire/smoke evacuations with moving to the adjacent smoke compartment at all staff meeting on 11/8/18. - New policy posted for staff reference on 11/15/18, policy revised to include horizontal evacuation into an adjacent	

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K 711	Continued From page 7 19.7.2.2 .	K 711	smoke compartment. Outcome: 100% of emergency preparedness policies upon annual review will contain regulatory review. Environment of care committee will review policy and approve annually. Results and discrepancies will be reported on the long term care quality meeting annually.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		12/9/18

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K 741	Continued From page 8 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoking regulations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoking regulations as required could cause a fire resulting in injury or death. The deficiency affected 1 of 2 major entrances to the facility, as well as the 450 residents and staff. The findings were: Observation on 10/24/2018 at 8:45 AM at the employee's entrance revealed that the facility did not post a No Smoking sign despite being a no smoking facility. No Smoking signs need to be posted at all main entrances to the facility. Interview with the facility maintenance manager at the time of observation acknowledged that no sign was posted, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.7.4 .	K 741	Correction for cited environment: 1. Posted non-smoking sign on employee entrance on 11/16/18. Identification of other residents: All residents/staff have the potential to be affected by failure to post non-smoking signs at main entrances of the building. Systematic changes and monitoring: Education on importance of non-smoking signs at main facility entrances completed at all staff meeting on 11/8/18. Outcome: 100% of main entrance doors will have a sign that indicates the facility is non-smoking. This annual audit will be collected by plant operations (or designee) and will be aggregated and reported annually at long term care quality meetings. All discrepancies will be investigated and reported.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on October 24, 2018.	E 000		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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 annually. 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 REQUIREMENT is not met as evidenced by: Document review and staff interview revealed that the facility failed to maintain and develop a policy and procedure for an 1135 waiver in accordance with 42 CFR 483.73. Failure to provide a policy and procedure could result in	E 026	Correction for cited environment: 1. Patient Evacuation and Shelter-In-Place policy was corrected on 10/30/18 and sent to environmental care committee for approval on 11/15/18.	12/9/18

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E 026	Continued From page 1 injury or death during an emergency. The deficiency affected 1 of 4 core elements of the Emergency Preparedness Program. The findings were: Document review of the Emergency Preparedness Plan on 10/24/2018 at 10:05 AM revealed that no policy and procedure addressing a waiver declared by the Secretary, in accordance with section 1135 was provided. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. REF: 42 CFR 483.73(b)(8)	E 026	Policy was approved at emergency preparedness committee on 11/13/18. Identification of other environments: All residents/staff have the potential to be affected by not having the 1135 waiver in place for care and treatment at an alternative care site identified by emergency management officials. Systematic changes and monitoring: - Education on 1135 waiver addition to policy completed at all staff meeting on 11/10/18. - New policy posted in policy manager for staff reference on 11/15/18. Outcome: 100% of emergency preparedness policies upon annual review will contain regulatory review. Environment of care committee will review policy and approve annually which will be reported on the long term care dashboard annually. Discrepancies will be investigated and reported.	