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 _____	**12/03/2021**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on December 3, 2021. .	E 000		
E 031 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), §485.625(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. *[For ICF/IIDs at §483.475(c):] (2) Contact	E 031		12/24/21

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

Electronically Signed | 12/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 031	Continued From page 1 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 develop and maintain the emergency preparedness contact information in accordance with §483.73(c). Failure to develop and maintain the emergency preparedness contact information could result in the supervising agency not being notified in an emergency. The deficiency affected the contact list in the emergency preparedness plan. The findings were: Document review on 12/03/2021 at 11:00 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: The State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. Interview with the facilities manager at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. .	E 031	Correction for cited resident/environment: The contact information for the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman have been added to the Contact list in Emergency Preparedness Manual, effective 12/04/2021. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain contacts as required. Systematic changes and monitoring: Quarterly review by the Emergency Preparedness Committee (EPC) will include a review of all required contact information to ensure facility documentation is compliant. Outcome: Emergency Preparedness Committee will ensure the Emergency Preparedness Manual is up-to-date, including current information on all required contacts.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on December	K 000		

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K 000	Continued From page 2 2, 2021 through December 3, 2021. Requirements for Long Term Care Facilities 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) construction built in 2016. The building was equipped with a supervised wet sprinkler system and dry sprinkler system, and an addressable fire alarm system. The facility had a capacity of 160 certified Medicare and Medicaid beds with a census of 108 residents. .	K 000		
K 222 SS=D	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	K 222		12/24/21

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K 222	Continued From page 3 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	K 222		

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K 222	Continued From page 4 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: 1. 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 12/2/2021 at 9:35 AM of the south doors by the 2nd floor east kitchen, leading to the outside patio and seating area, revealed that the force applied to open the left leaf was measured to be in excess of 30 lbf. Interview with the facility maintenance staff at the time of observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5.1 2. 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 result in injury or death during an emergency. The deficiency affected one (1) of numerous exits. The findings were: Observation on 12/2/2021 at 3:13 PM at the first	K 222	Correction for cited Residents/environment: 1. The south doors on the 2nd floor east of kitchen leading to the outside patio and seating area have been adjusted and repaired. 2. The 1st floor stairwell 3 door has been repaired, the 15 second delayed egress hardware has been repaired with alarm sounding and door unlocking automatically. 3. The gate outside, between Cottonwood and Pine, will remained locked. The staff working in the area were educated on the procedure to unlock gate for instant use. Keys will be kept by staff working in the area at all times. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain egress as required. Systematic Changes and monitoring: Monthly audit of egress doors to be completed by Plant Ops via preventive maintenance electronic system. Education to staff 12/06/2021 regarding egress doors function. Outcome: 100% of egress doors will activate an audible signal in the vicinity of the door and release the door after the 15 seconds. Plant Ops will investigate	

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K 222	Continued From page 5 floor stairwell 3 door revealed the delayed egress locking system failed to operate as designed. When tested, the release process failed to activate an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds. The door could only be released by badge access. Interview with the facility maintenance staff at the time of observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 18.2.2.2.4(2); 7.2.1.6.1.1(3) 3. 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 result in injury or death during an emergency. The deficiency affected one (1) of numerous exits. The findings were: Observation on 12/2/2021 at 3:50 PM at the outside gate between the Cottonwood and Pine, in the exit pathway, revealed the gate was locked with a chain and keyed lock. When requested to unlock the door, it was discovered that the key for the lock was kept at the front desk in a box. Interview with the facility maintenance staff at the time of observation acknowledged the locked gate, and indicated they were not aware of the requirement.	K 222	discrepancies, and report findings and resolution to the Administrator.	

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K 222	Continued From page 6 Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.5.1, 19.2.2.2.6 .	K 222		
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 interview, the facility failed to maintain doors with self-closing devices in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain doors with self-closing as required could result in injury or death during an emergency. The deficiency affected two (2) of numerous doors with self-closing devices. The findings were: Observation on 12/2/2021 at 11:25 AM at linen room 290A revealed the doors failed to operate as designed. When dropped tested with no initial	K 223	Correction for cited residents/environment: The self-closing devices on the doors of 290A and the door between the kitchen and the dock has been adjusted so that when dropped, the positively latch into the frame. Education to staff 12/20/2021 regarding automatic self-closing devices. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain smoke	12/24/21

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K 223	Continued From page 7 motion the door failed to shut and latch. Additional observation at the kitchen doors leading into the dock found that the doors failed to shut and latch when dropped tested with no initial motion. Interview with the facility maintenance staff at the time of observation acknowledged the excess force, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1, 7.2.1.8 .	K 223	doors. Systematic changes and monitoring: Monthly audit of all smoke barrier doors to be completed by plant ops via preventive maintenance electronic system. Outcome: 100% of doors with self-closing devices close and positively latch into the frame when dropped. Plant Ops will investigate discrepancies, and report findings and resolution to the Administrator.	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance 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 one (1) of six (6) stairwells in the facility. The findings were:	K 225	Correction for cited residents/environment: Stairwell S-5, plant ops repaired the missing fasteners and repaired the door making one solid surface. The storage in stairwell S-1 has been removed. Plant Ops provided education to staff and contractors regarding stairwell	12/24/21

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K 225	Continued From page 8 Observation on 12/2/2021 at 9:50 AM in stairwell S-5 on the first floor revealed the back of the rated door had a small hole in it. Additionally, the door was missing the middle two fasteners of the middle hinge. The surveyor was able to see through the hole in the back of the door, and through the missing fastener location. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101: Section 18.2.2.3; 7.2.1.15 2. Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance 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 one (1) of six (6) stairwells in the facility. The findings were: Observation on 12/2/2021 at 12:02 PM in stairwell S-1 revealed combustibles stored on the 2nd floor landing and on the landing between 2nd and 1st floors. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency.	K 225	requirements on 12/6/2021. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain egress doors and paths of egress as required. Systematic changes and monitoring: Monthly monitoring of egress doors and stairwell spaces to be completed by plant ops via preventive maintenance electronic system. Outcome: 100% of doors have hardware and all areas in stairwells are free from storage. Plant Ops will investigate discrepancies, and report findings and resolution to the Administrator.	

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K 225	Continued From page 9 REF: 2012 NFPA 101: Section 19.2.2.3; 7.2.2.5.1.1; 7.1.3.2.3 .	K 225		
K 351 SS=D	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 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 REQUIREMENT 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 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 rooms. The findings were: 1. Observation on 12/2/21 at 10:09 AM in the lobby gift shop revealed obstructions near the	K 351	Correction for cited residents/environment: The light fixtures in the Gift Shop have been replace with fixtures that are in-compliance with 2012 NFPA 101, 2011 NFPA 25, and 2010 NFPA 13. The storage area in the Kitchen has been removed and a red line has been added 18 inches from the ceiling. Identification of other residents: All resident/staff have the potential to be	12/24/21

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K 351	Continued From page 10 sprinkler heads. Obstructions were two light fixtures to the room center of the sprinkler heads. Interview with the facility maintenance staff at the time of observations acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 8.6.5 2. Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected the entire facility. The findings were: Observation on 12/3/2021 at 8:52 AM in the kitchen revealed objects in the south east storage wall stacked to the ceiling within several inches of the sprinkler head. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section 5.2.1.2	K 351	affected by failure to maintain proper storage height. Systematic changes and monitoring: Monthly audit of storage and monitoring of new installation of fixtures will be completed by plant ops via preventive maintenance electronic system and redline installed. Education to staff will be completed on 12/27/2021 regarding storage practices. Outcome: 100% of sprinkler heads will be free of obstruction and there will be no storage within 18 inches of the ceiling. Plant Ops will investigate discrepancies, and report findings and resolution to the Administrator.	

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K 351	Continued From page 11 .	K 351		
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: Based on observation and staff interview, the facility failed to conduct fire extinguisher inspections in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to conduct fire extinguisher inspections as required may lead to extinguisher not functioning resulting in injury or death during an emergency. The deficiencies affected several of numerous fire extinguishers in the facility. The findings were: Observation on 12/2/2021 at 9:38 AM in the 2nd floor south kitchen seating area found the fire extinguisher not signed off or inspected for November of 2021. Further observation found an additional fire extinguisher by basement room 033 where the signoff for November of 2021 was also missing. Additional observation of another extinguisher revealed it was not signed off for several months while being used as a spare prior to being placed in the basement south corridor. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of	K 355	Correction for cited residents/environment: The 3 portable fire extinguishers identified have been brought to compliance with NFPA 10. Education to staff completed 12/06/2021 regarding fire extinguisher check requirements. Identification of other residents: All residents/staff have the potential to be affected by failure to maintain fire extinguishers as required. Systematic changes and monitoring: Monthly fire extinguisher check will be done by plant ops with life safety plans, identifying the location of each fire extinguisher. Monthly inspections will be recorded electronically via preventive maintenance system. Outcome: 100% of fire extinguishers will be in compliance with NFPA 10. Plant Ops will investigate discrepancies, and report	12/24/21

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 _____	**12/03/2021**

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 355	Continued From page 12 exit acknowledged the deficiency. REF: 2010 NFPA 10: Section 7.2.1; 7.2.4 .	K 355	findings and resolution to the Administrator.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to spray combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to spray combustible decorations as required could quickly increase a fire's size in the building during an emergency resulting in injury or death. The deficiency affected several of numerous rooms in the building. The findings were: Observation on 12/2/2021 at 11:37 AM in a resident room in the 2400 hall revealed a large	K 753	Correction for cited residents/environment: The facility will purchase tag so that plant ops can tag and log all items introduced to the facility requiring flame retardant treatment. Identification of other residents: All resident/staff have the potential to be affected by failure to treat and maintain logs of items needing fire retardant. Systematic changes and monitoring: Monthly audit of items introduced to the	12/24/21

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 _____	**12/03/2021**

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K 753	Continued From page 13 crocheted flag approximately seven (7) feet long by four (4) feet tall, hanging on the right hand entry wall. No tag was placed on the flag to state when, or if, it was sprayed. In reviewing records it was found that no written record was kept for sprayed decorations, other than when placed on object. Several other large fabric decorations (such as quilts) were observed in other resident rooms. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facilities manager at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.5.1, 19.7.5.6, 10.3.1	K 753	facility will be completed by plant ops via preventive maintenance schedule. Education to staff will be completed 12/27/2021 regarding flame retardant needs, uses and logs. Outcome: 100% of all materials needing flame retardant will be treated and logged. Plant Ops will investigate discrepancies, and report findings and resolution to the Administrator.	