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 _____	**03/08/2023**

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 03/08/2023. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	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), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact	E 031		3/9/23

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

Electronically Signed | 03/31/2023

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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 03/08/2023 at 10:13 AM revealed that the contact list in the emergency preparedness plan was missing contact information for: the Office of the State Long-Term Care Ombudsman. Interview with the facility life safety 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.	E 031	Correction: Contact information for the Office of the State Long-Term Care Ombudsman added to Emergency Preparedness Plan on 3/9/23 by Executive assistant. Environment of Care committee will review and update annually and as needed.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/07/23 through 03/08/23. Requirements for Long Term Care Facilities	K 000		

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K 000	Continued From page 2 Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association The facility was a fully sprinklered two story building with a basement of Type 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 113 residents. The findings that follow demonstrate noncompliance with 42 CFR 48.90.	K 000		
K 223 SS=F	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 provide doors with self-closing devices in accordance with the 2012 NFPA 101,	K 223	Past noncompliance: no plan of correction required.	

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K 223	Continued From page 3 Life Safety Code. Failure to provide as required could result in the spread of fire and smoke which could result in injury or death in the event of a fire. The deficiency affected six (6) of numerous doors in the facility and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 starting at 9:00 AM revealed multiple doors equipped with self-closing devices. When dropped with no initial motion they failed to close and latch. The doors that failed to latch included the south kitchen door, kitchen door leading to the dock, door TCFL #3, linen closet 128, linen closet 290A, and roof access room 256. Interview with the facility life safety 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 7.2.1.8.2	K 223		
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: Based on observation and staff interview, the	K 225	Correction:	3/8/23

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K 225	Continued From page 4 facility failed to maintain stairwells clear of storage materials in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain clear stairwells 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 and could potentially impact all residents, staff, and visitors.. The findings were: Observation on 03/07/2023 at 1:41 PM in stairwell 2 revealed combustibles stored on the 2nd floor landing. An exit enclosure shall not be used for any purpose that has the potential to interfere with it use as an exit. Interview with the facility maintenance 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 19.2.2.3; 7.2.2.5.1.1; 7.1.3.2.3	K 225	Life Safety Officer removed storage from the stairwell landing to keep all stairwells clear for access to the Exit in accordance with 2012 NFPA 101 Chapters 19 and 7. Completed on 03/08/2023 Systematic change and monitoring: Monthly rounding will be conducted by the assigned plant ops personnel via electronic PM system to ensure there is no storage in any of the facilities stairwells. Report will be sent to and reviewed by Plant-Ops manager. Outcome: 100 percent of stairwell will be kept clear of all storage. Plant-Ops will notify Administration of any discrepancies.	
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, 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 REQUIREMENT is not met as evidenced by:	K 271		3/16/23

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K 271	Continued From page 5 Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected multiple exit discharges and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/23 at 10:29 AM at the bingo hall/activities room revealed that the sidewalk to the public way was partially covered in snow and ice, leaving a several inch tall bump to traverse to the exit. Further observation on 03/07/23 at 10:32 AM revealed that the exit discharge from stairwell #4 would require traversing the same section of sidewalk. Additionally it was found that the pathway leading from the stairwell door to the activities room exit had been partially cleared and had veered away from the concrete sidewalk and instead cut across the grass landscaping. Interview with the facility life safety 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, 19.2.7, 19.7.3.1; 7.1.10.1, 7.1.6.4	K 271	Plant Ops technician completed the following corrections: #1. The egress path between the Bingo Hall patio and the public way has been cleared down to the concrete sidewalk. Completion date 03/15/2023 #2. The egress path leading from stairwell #4 has been cleared down to concrete sidewalk to the public way. The path is no longer going across the grass landscaping. Completion date 03/16/2023 Systematic change and monitoring: Assigned Plant-Ops personnel have been educated on the correct egress pathway and will ensure that the pathways on the concrete sidewalk are maintained regularly as needed. Outcome: All egress pathways have been cleared down to the sidewalk.	
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	K 321		3/17/23

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K 321	Continued From page 6 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in the spread of fire and smoke which could result in injury or death in the event of a fire. The deficiency affected the one (1) of two (2) elevator machine rooms and could potentially impact all residents, staff, and visitors. The findings were:	K 321	Plant Ops technician completed the following corrections: #1. The 2.5-inch hole in the wall was repaired in accordance with the National Gypsum Association and 2012 NFPA 101 Chapter 19 removing the deficiency from elevator room 027. Completion date 03/15/2023 #2. The large sections of gypsum removed from storage adjacent future laundry are have been repaired in	

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K 321	Continued From page 7 Observation on 03/07/2023 at 9:45 AM in elevator machine room 027, revealed an approximate 2.5" x 2.5" hole immediately to the left of the room air conditioner. Interview with the facility life safety 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: 19.3.2.1, 8.7.1, 19.3.2.1.2, 8.4.4.1 Observation on 03/07/2023 at 10:02 AM in the basement storage room next to future laundry, revealed multiple sections of walls removed totaling several square feet, open to the foundation wall behind it. Interview with the facility life safety 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: 19.3.2.1, 8.7.1, 19.3.2.1.2, 8.4.4.1	K 321	accordance with the National Gypsum Association and 2012 NFPA 101 chapter 19 removing the deficiency. Completion date 03/17/2023 Systematic change and monitoring: Monthly rounding will be conducted by the assigned plant-ops personnel to ensure that no areas of gypsum have been removed. The report of the monthly rounding will be given to the Plant-Ops manager to ensure that the deficient practices are clear. Plant-Ops will investigate any discrepancies and repair as needed.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		3/17/23

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K 324	Continued From page 8 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and could potentially impact all kitchen staff and visitors. The findings were: Observation on 03/07/2023 at 9:05 AM in the kitchen revealed a wheeled gas-fired cooktop located beneath the grease hood and fire	K 324	Correction: The deficiency has been corrected by Plant Ops technician. The kitchen equipment now has a permanent marking to ensure they are returned to the approved location beneath the fire suppression system in accordance with 2011 NFPA 96 chapter 12 and 2012 NFPA 101 chapter 19. Completion date 03/17/2023 Systematic change and monitoring: Daily rounding will be conducted by kitchen supervisor to ensure that the cooking equipment is in approved location. Outcome: All protected equipment will be maintained under the fire suppression	

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K 324	Continued From page 9 suppression system. Further observation revealed that no means was provided to ensure that the cooktop is returned to the approved location beneath the fire suppression system after being moved for service or cleaning. Interview with the facility life safety 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 19.3.2.5.5 and 9.2.3 2011 NFPA 96, Section 12.1.2.3	K 324	system. Any discrepancies will be reported to kitchen manager.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced	K 341		3/15/23

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K 341	Continued From page 10 by: Based on observation and staff interview, the facility failed to install fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. Failure to install fire alarm systems as required could result in delayed response and occupant notification which could result in injury or death in the event of a fire. The deficiency affected the fire alarm system and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 3:16 PM in the above ceiling corridor space by doors 2100 revealed a junction box for the fire alarm wiring had been left open. Interview with the facility life safety 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 Sections 19.3.4.1; 9.6.1.3 2010 NFPA 72 Section 26.3.4.3	K 341	Correction: The cover for the deficient junction box has been installed by the Plant Ops technician and is no longer deficient. Completion date 03/15/2023 Systematic changes and monitoring: All contractors will be monitored upon completion by assigned Plant-Ops personnel. Any discrepancies will be corrected and Administration will be notified. Plant-Ops will conduct annual rounding via electronic PM system. Outcome: 100 percent of junction boxes will be covered. Any discrepancies will be repaired and Administration will be notified.	
K 345 SS=D	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.	K 345		3/9/23

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K 345	Continued From page 11 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain the fire alarm system as required could result in delayed response and occupant notification which could result in injury or death in the event of a fire. The deficiency affected the fire alarm system and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 10:52 AM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm was expired. Interview with the facility life safety 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 Sections 19.3.4.1; 9.6.1.3 2010 NFPA 72 Section 26.3.4.3	K 345	Correction: A new UL listing for the fire panel was acquired through the fire service contractor and displayed Per NFPA 72 and NFPA 101. Completion date 03/09/2023 Systematic changes and monitoring: Fire alarm contractor will update annually and assigned Plant-Ops personnel will be assigned via electronic PM system to update is conducted as needed. Outcome: Fire alarm panel will have new UL listing annually.	
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	K 351		3/22/23

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	535022	A. BUILDING **01** B. WING _____	**03/08/2023**

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THE LEGACY LIVING AND REHABILITATION CENTER	**1000 S DOUGLAS HWY** **GILLETTE, WY 82716**

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K 351	Continued From page 12 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 have sprinkler systems installed in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to install sprinkler systems as required could result in the system working improperly which could allow for the spread of smoke and fire which could result in injury or death. The deficiency affected the fire sprinkler system and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 9:55 AM at the main sprinkler riser revealed no hydraulic design information nameplate was provided on the fire sprinkler riser as prescribed. Interview with staff revealed that none of the risers in the building had a hydraulic nameplate. Interview with the facility life safety at time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit	K 351	Correction: #1. All hydraulic calculation tags for the sprinkler system were provided by original installer of sprinkler system. Tags were installed in accordance with 2012 NFPA 101 and 2010 NFPA 13. Completion date 03/22/2023 #2. All storage closer than 18 inches from the ceiling has been removed by Plant-Ops. Systematic changes and monitoring #1. Hydraulic Calculation Tags have been installed and will be monitored by assigned Plant-Ops staff and by fire contractor annually. #2. Monthly rounding will be conducted by assigned Plant-Ops personnel via electronic PM system to ensure that storage is within code. Outcome: #1. Hydraulic calc tags are in place. #2. No storage is closer than 18 inches of the ceiling.	

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K 351	Continued From page 13 acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.1.1(1) 2010 NFPA 13, Section 24.5.1 Observation on 03/07/23 at 8:52 AM at the birch nurses station revealed objects stacked to the ceiling within several inches of the sprinkler head. Interview with the facility life safety 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: 19.3.5.1; 9.7.1.1(1) 2010 NFPA 13, Section 8.6.6.1	K 351		
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 _____	K 353		3/15/23

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K 353	Continued From page 14 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 facility failed to maintain the fire sprinkler system 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. Failure to properly maintain the fire sprinkler system could result in the system working improperly which could allow for the spread of smoke and fire which could result in injury or death. The deficiency affected the fire sprinkler system and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 3:16 PM in the above ceiling corridor space to the south of doors 2100, it was observed that several IT wires draped across the fire sprinkler pipe. Further observation on 03/07/23 at 3:24 PM in the above ceiling corridor space to the north of doors 2100 it was observed that an IT wire was wrapped around the fire sprinkler pipe. Interview with the facility life safety at the time of observations 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 19.3.5.1, 9.7.5 2011 NFPA 25, Section: 5.2.2.2	K 353	Correction: All wiring above ceiling in corridor space to the south of doors 2100 have been removed from the sprinkler system by Plant-Ops in accordance with 2012 NFPA 101 and 2011 NFPA 25 Completion date 03/15/2023 Systematic changes and monitoring: Plant-ops will conduct inspection after each above ceiling work to ensure that nothing is touching the sprinkler piping. Any discrepancies will be fixed immediately and administration will be notified. Outcome: All wiring has been removed from touching the sprinkler system.	

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K 355	Continued From page 15	K 355		
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 install 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 install portable fire extinguishers as required could result in the spread of smoke and fire which could result in injury or death. The deficiency affected two (2) of many portable fire extinguishers in the facility and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 10:58 AM in the theater room 104, by the south door revealed a portable fire extinguisher sitting on the floor, unsecured. Further observation by the north door into the theater room 104, revealed a second portable fire extinguisher sitting on the floor, unsecured. Interview with the facility life safety 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: 19.3.5.12	K 355	Correction: Plant Operations technician mounted both fire extinguishers to the wall in accordance with 2012 NFPA 101 and 2011 NFPA 25. Completion date 03/15/2023 Systematic changes and monitoring Any newly introduced fire extinguisher to the facility will be mounted per code by assigned Plant-Ops personnel. Assigned Plant-Ops personnel via electronic PM system will conduct monthly rounding to ensure all fire extinguishers are securely mounted. Any discrepancies will be fixed up finding Outcome: 100 percent of all facilities fire extinguishers are securely mounted.	3/15/23

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K 355	Continued From page 16 2010 NFPA 10, Sections: 6.1.3.4, 6.1.3.8.3	K 355		
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable space heaters in accordance with the 2012 NFPA 101, Life Safety Code. The failure to properly utilize portable space heaters could result in injury or death due to an in increased risk of fire. The deficiency affected three (3) of multiple rooms and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 10:39 AM in room 101D revealed a portable space heater. The area is a non-sleeping staff area, however no documentation was provided to be able to determine the maximum temperature of the heating elements. Observation on 03/07/2023 at 10:55 AM at the reception desk, which is in the buildings atrium, revealed a portable space heater. The area is open to resident areas and is frequently visited by residents. Observation on 03/07/2023 at 11:15 AM in room 134 revealed a portable space heater. The area is a non-sleeping staff area, however no documentation was provided to be able to determine the maximum temperature of the heating elements.	K 781	Correction: All space heaters, not in compliance, have been removed from the areas by the Life Safety Officer. Completion date 03/07/2023 Systematic changes: Any staff requesting a space heater in non-resident areas, must do so through Plant-Ops. Plant-Ops will conduct monthly rounding as needed to ensure heaters are to code. Any discrepancies will be removed immediately for further evaluation. Outcome: All non-compliant space heaters have been removed from the facility.	3/8/23

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K 781	Continued From page 17 Interview with the facility life safety 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.	K 781		
K 919 SS=D	Ref: 2012 NFPA 101, Section 19.7.8 Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in electrical failure which could result in injury or death. The deficiency affect multiple electrical panels located in the kitchen and could potentially impact kitchen staff and visitors. The findings were: Observation on 03/07/2023 at 9:08 AM in the kitchen found that a trash can was being stored in front of several electrical panels. A working space of three (3) feet is to be maintained.	K 919	Correction: Life Safety Officer removed trash can from in front of electrical panels. All kitchen staff education was conducted on 03/29/2023 on the 3-foot clearance in front of the electrical panel. Completed on 03/29/2023 Systematic changes and monitoring: Kitchen supervisor will conduct daily rounding to ensure that no storage is being kept within 3 feet of the electrical panels in the kitchen. Kitchen manager will conduct education to kitchen staff to ensure that code is being maintained. Education will be completed upon hire and quarterly as needed.	3/29/23

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K 919	Continued From page 18 Interview with the facility life safety 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: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 210.8(B)(5)	K 919	Outcome: Storage was removed from in front of the electrical panel.	
K 932 SS=D	Features of Fire Protection - Other CFR(s): NFPA 101 Features of Fire Protection - Other List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection 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. Chapter 15 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store flammable gases in accordance with the 2012 NFPA 99, Health Care Facilities Code, and the 2012 NFPA 30, Flammable and Combustible Liquids Code. The failure to store flammable gases as required may result in the spread of smoke or fire which could result in injury or death. The deficiency affect the boiler room and could potentially impact all residents, staff, and visitors. The findings were: Observation on 03/07/2023 at 8:46 AM in the basement boiler room, revealed a small tank of dissolved acetylene, (acetylene is dissolved in acetone).	K 932	Correction: Life Safety Officer immediately moved flammable gas tank upon discovery. All Plant-Ops staff were educated about the proper storage of flammable gas. Completed on 03/07/2023 Systematic changes and monitoring: Assigned plant-ops personnel will conduct monthly rounding to ensure that the storage of flammable gasses is being done to code. Any discrepancies found will be immediately fixed and Administration will be notified. Outcome: All flammable gasses are stored per NFPA 99 and NFPA 30.	3/8/23

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K 932	Continued From page 19 Interview with the facility life safety 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 15.3.1, 15.3.2 2012 NFPA 30: 9.3.6	K 932		