STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy Living and Rehabilitation Center	1000 S Douglas Way , Gillette, Wyoming, 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
K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 09/16/2025 and 09/17/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90, except as otherwise provided in this 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 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 81 residents. The findings that follow demonstrate noncompliance with 42 CFR 48.90.	K0000		09/25/2025
K0222 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	K0222	Corrective Action: Nuisance alarm was disengaged on doors on 9/18/25. Doors on stair 3 at level 2, stair 4 at level 2, and stair 2 at level 1 all open within delayed egress time restraints. Identification of others: All delayed egress doors in facility tested with stopwatch timing. Systemic Changes: Preventative Maintenance reviews updated in system to quarterly review. Stopwatch timing implemented with reviews for all delayed egress doors. Monitoring: Quarterly preventative maintenance audit and report to QAPI committee.	10/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K0222 SS = E	Continued from page 1 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 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure the time to open a door when equipped with delayed egress. Failure to ensure the proper operation of doors in a means of egress could impede egress leading to injury or death in the event of an emergency. The deficiency affected three (3) of multiple doors and could potentially affect all	K0222		

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K0222 SS = E	Continued from page 2 residents, staff, and visitors. The findings were: Observation on 09/16/2025 at 8:45 AM revealed delayed-egress locking arrangement on the stair 3 egress door at level 2 took greater than fifteen (15) seconds to release the lock in the direction of egress. Observation on 09/16/2025 at 10:10 AM revealed the delayed-egress locking arrangement on the stair 4 egress door at level 2 took greater than fifteen (15) seconds to release the lock in the direction of egress. Observation on 09/16/2025 at 2:35 PM revealed the delayed-egress locking arrangement on the stair 2 egress door at level 1 took greater than fifteen (15) seconds to release the lock in the direction of egress. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections 19.2.2.2.4, 7.2.1.6.1	K0222		
K0223 SS = E	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	K0223	Corrective Action: All doors with self-closing devices will latch. Cross corridor rated fire doors, Linen room rated fire door, Linen room rated fire door, Storage room rated fire door, Storage room rated fire door #145G, Nutrition room rated fire door, Cross corridor rated fire doors, and soiled linen rated fire door #031 were repaired 9/18/25. Clean Utility room rated fire door #253 hardware will be replaced by 11/26/25 due to contractor availability and supplies. Identification of others: All facility self-closure and latching doors evaluated on 9/18/25. Systemic Changes: Updated monthly safety sweep to include doors with self-closing devices, fire doors, and smoke compartment doors. Preventative Maintenance schedule updated to include annual evaluation. Staff education of Safety Sweeps at staff meeting 10/9/25.	11/26/2025

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K0223 SS = E	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position unless held open by a release device in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure self-closing doors close and latch could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected ten (10) of multiple doors and could potentially affect all residents, staff, and visitors. The findings were: Observation on 09/16/2025 at 9:30 AM revealed the activities storage room 285A was protected with a self-closing door due to the room being greater than 50 SF in size and the storage of flammable or combustible materials. Further observation revealed the self-closing door failed to close and latch, keeping the door in the closed position. Further observations beginning at 9:35 AM revealed the following self-closing doors were equipped with closing devices and failed to close and latch, keeping the doors in the closed position: 1. Cross corridor rated fire doors # 2400-1 failed to latch at 9:35 AM 2. Clean Utility room rated fire door #253 failed to latch at 10:25 AM. Further observation revealed the door was missing a lever and latching hardware. 3. Linen room rated fire door #128B failed to latch at 11:30 AM 4. Linen room rated fire door #144A failed to latch at 11:45 AM 5. Storage room rated fire door #145E failed to latch at 11:50 AM 6. Storage room rated fire door #145G failed to latch at 11:50 AM 7. Nutrition room rated fire door #159A failed to latch at 1:50 PM 8. Cross corridor rated fire doors # 2300-1 failed to latch at 2:05 PM	K0223	Continued from page 3 Monitoring: Quarterly preventative maintenance audit and monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	

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K0223 SS = E	Continued from page 4 9. Soiled Linen rated fire door #031 failed to latch at 3:55 PM Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7.1, 7.2.1.8	K0223		
K0271 SS = E	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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide an exit discharge that provides a level walking surface meeting the provisions of 2012 NFPA 101, Life Safety Code with respect to abrupt changes in walking surfaces in the means of egress. Failure to provide a level walking surface at the means of egress could delay or impede egress in an emergency leading to injury or death. The deficiency affected two (2) of multiple exits. The deficiency could affect all residents, staff, and visitors. The findings were: Observation on 09/16/2025 at 12:08 PM revealed the exit path from the Spruce courtyard included a concrete walking surface with an abrupt change in elevation of walking surface. 2012 NFPA 101, Life Safety Code, specifies that abrupt changes in elevation of walking surfaces shall not exceed one-quarter inch (1/4”). Observation on 09/16/2025 at 12:35 PM revealed the exit path from the Chapel courtyard included a concrete	K0271	Corrective Action: Exit discharge will provide a level walking surface. Spruce courtyard and Chapel courtyard will have concrete walking surfaces repaired by contracted company by 10/26/25. Identification of Others: Complete facility-wide inspection completed on 9/18/25 of all walking surfaces. Systemic Changes: Education to staff in October All-staff meeting on 10/9/25 for requirement that exits, and walking surfaces must remain clear, unobstructed and level and reporting immediately and how to report. Monthly safety sweep updated to include discharge from exits. Monitoring: Monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	10/26/2025

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K0271 SS = E	Continued from page 5 walking surface with an abrupt change in elevation of walking surface. 2012 NFPA 101, Life Safety Code, specifies that abrupt changes in elevation of walking surfaces shall not exceed one-quarter inch (1/4”). Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.2.1, 7.1.6	K0271		
K0321 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. 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)	K0321	Corrective Action: Hazard Areas are protected. Laundry Room Door 116 repaired holes in door frame 10/2/25.Hazardous Materials Storage room in the basement level had closing device installed 10/1/25. Identification of others: Full facility inspections of all hazardous areas completed 9/18/25. Systemic changes: Preventative Maintenance schedule updated to include inspection to hazardous area enclosures and doors annually. Door conditions included in monthly safety sweeps. Monitoring: Quarterly preventative maintenance audit and monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	10/02/2025

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K0321 SS = D	Continued from page 6 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas are protected by a fire barrier having a 1-hour fire resistance rating (with 3/4 -hour fire rated doors) in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain fire rated fire doors protecting hazardous areas could allow for the spread of smoke and fire leading to injury or death in the event of a fire. The deficiency affected one (1) of multiple doors. The deficiency affected all residents and staff using the hazardous area. The findings were: Observation on 09/16/2025 at 11:35 AM revealed the laundry room door 116 was a self-closing 3/4 hour rated door with a power operator. Further observations revealed the facility had removed a closing device from the self-closing door and failed to repair holes in the top of the door frame and door where the field modifications to the door assembly had been performed. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7, 8.3, 2010 NFPA 80 Sections, 5.2.4.2 (1), 6.1.4.2.1 Observation on 09/16/2025 at 4:05 PM revealed the hazardous materials storage room in the basement next to the east elevator machine room, did not have a door closure on the door. Further observations revealed the room to have measured to be approximately 54 square feet (8'-10.5" by 6'-1").	K0321		

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K0321 SS = D	Continued from page 7 Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7, 8.3, 2010 NFPA 80 Sections, 5.2.4.2 (1), 6.1.4.2.1	K0321		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of maintenance and testing of the fire alarm system in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain fire alarm systems could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The deficiency could affect all residents, staff, and visitors. The findings were: Document review on 08/29/2025 starting at 9:35 AM revealed the facility tested the fire alarm system on April 18th, and July 14th, 2025, but failed to provide documentation of the following tests in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code: a) Monthly activation of supervising station alarm systems - Table 14.4.5(24) b) Smoke detector sensitivity test – Table 14.4.5(15)i Interview with the facility administrator, facility	K0345	Corrective Action: Fire alarm system will be tested and maintained. Smoke detector sensitivity test completed 10/2/25. Education provided to plant ops department that silent alarms do not count towards monthly activation tests. Identification of Others: Review of required test completed for year. Systemic Changes: Preventative maintenance schedule updated to reflect fire drills, alarm activation, and sensitivity tests. Process added to TELS system for tracking. Monitoring: Monthly review of fire alarm system preventative maintenance and report to QAPI committee.	10/15/2025

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K0345 SS = F	Continued from page 8 director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Sections 19.7.6, 4.6.12, 9.6.1.5 and 2010 NFPA 72, Sections 14.4.5	K0345		
K0351 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 STANDARD is NOT MET as evidenced by: Based on site observations and staff interview, the facility failed ensure proper installation of the fire sprinkler systems in accordance with 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to ensure proper installation of the fire sprinkler systems could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were:	K0351	Correction Action: The facility will ensure proper installation of the fire sprinkler system. The items stored in room 205 storage were immediately removed. Shelf height was adjusted in compliance with 18" clearance rule. Line added to wall for visual identification with photos on 9/19/25. Ceiling mounted escutcheon inside room 1411 will be repaired by 10/26/25. Identification for others: All areas audited and cleared of storage or obstructions to maintain a minimum of 18" clearance. Education to all staff in September staff meeting on 18" clearance rule. Systemic changes: Updated safety sweeps to include evaluation of escutcheons and 18" clearance rule. Monitoring: monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	10/26/2025

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K0351 SS = D	Continued from page 9 Observations on 09/16/2025 at 10:00 AM revealed the facility failed to provide adequate clearance between the fire sprinkler system and the storage in storage room 205 located inside the PT gym. The storage was within eighteen inches (18") of the ceiling-mounted fire sprinkler deflectors creating an obstruction to sprinkler discharge pattern development. Observations 09/16/2025 at 2:55 PM revealed the fire sprinkler escutcheon for the ceiling mounted fire sprinkler in the bathroom inside room 1411 was loose and not tight to the ceiling, exposing the annular space around the sprinkler. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.3.5, 9.7.1, and 2010 NFPA 13 Section 8.3.2	K0351		
K0353 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	K0353	Corrective Action: The Facility will maintain the sprinkler system. Electrical cables resting on the fire sprinkler pipe above door 129G were removed 9/18/25 Identification of others: Annual preventative maintenance inspection above ceilings. Systemic Changes: Implementation of above ceiling permits for vendors working above the ceiling grid. Preventative Maintenance schedule updated to include annual audits of above ceiling areas and fire penetration wall assessments. Monitoring: Quarterly preventative maintenance audit. Report monthly to QAPI committee.	10/26/2025

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K0353 SS = D	Continued from page 10 This STANDARD is NOT MET as evidenced by: Based on observation, document review and staff interview, the facility failed to maintain and provide documentation of required maintenance for the water-based fire protection systems in accordance with 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency could affect the entire fire sprinkler system. The deficiency could affect all residents, staff, and visitors at the facility. The findings were: Observation on 09/16/2025 at 11:15 AM revealed electrical cables resting on fire sprinkler system piping above the ceiling near door 129G. Sprinkler piping shall not be subjected to external loads by materials resting on pipe or hung from pipe. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Sections 5.2.2.2	K0353		
K0511 SS = E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observations and staff interview, the facility failed to ensure electrical boxes were installed in accordance with the 2011 NFPA 70, National Electrical	K0511	Corrective Action: Facility will install electrical receptacles within compliance. Wall mounted box in room 2202 was fitted with a compliant cover plate and exposed electrical cables properly enclosed on 9/24/25. The electrical box under the desk at the Memory care wing nurses' station was repaired and fitted with a complete, secure cover plate and exposed electrical cables properly enclosed on 9/17/25. Identification of others: Facility review of all electrical receptacles completed 9/16/25. Systemic changes: Staff to be educated on reporting of uncovered/loose electrical boxes or exposed wiring at All staff meeting 10/9/25. Initiation of safety sweeps to identify and rectify deficiencies.	10/09/2025

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K0511 SS = E	Continued from page 11 Code. Failure to install electrical receptacles in accordance with the 2011 NFPA 70, National Electrical Code could lead to injury or death in the event of exposure to energized electrical systems. The findings could affect all residents and staff utilizing the facility. The findings included two (2) of multiple electrical boxes. Observations on 09/16/2025 at 10:15 AM in room 2202 revealed a wall mounted electrical box without a cover plate and exposed electrical cables. Observations on 09/16/2025 at 2:40 PM at the Memory Care nurse station revealed a wall mounted electrical box under the desk with a partially installed cover plate and exposed electrical cables. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.5.1.1, 9.1.2, 2011 and NFPA 70 Section 314.25, 406.6	K0511	Continued from page 11 Monitoring: monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	
K0781 SS = D	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 STANDARD is NOT MET as evidenced by: Based on observations and staff interview, the facility failed to ensure portable space heaters used in nonsleeping staff and employee areas were provided with heating elements that would not exceed 212 degrees Fahrenheit (100 degrees Celsius) in accordance with the 2012 NFPA 101, Life Safety Code. Failure to ensure portable space heaters are provided with the required high temperature safety limits for their heating	K0781	Corrective Action: The facility will not have portable space heaters in the facility except when used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). Portable space heater and electrical splitter removed from hair salon room 114 on 9/17/25. Space heater was then removed from facility. Identification of others: Personal portable heaters prohibited in the facility and removed from all areas by 10/26/25. (exception emergency approved Plant Ops heater for loss of heat) Systemic Changes: Staff education on NFPA requirements for portable space heaters in October all-staff 10/9/25. Update monthly safety sweep to include observations for space heaters. Monitoring: monthly review of safety sweep compliance	10/26/2025

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K0781 SS = D	Continued from page 12 elements could increase the risk of fire leading to injury or death. The findings affected all staff in the reception office. The findings were: Observations on 09/16/2025 at 12:20 PM revealed a portable space heater inside the hair salon room 114 plugged into an electrical receptacle splitter. Further observation and staff interview revealed the portable space heaters did not include manufacturer's documentation that the heating element would not exceed 212 degrees Fahrenheit (100 degrees Celsius) in accordance with the 2012 NFPA 101, Life Safety Code. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Section 19.7.8	K0781	Continued from page 12 and concerns. Report monthly to QAPI committee.	
K0918 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily	K0918	Corrective Action: Essential Electric System Maintenance and testing will be completed. Four-hour generator testing performed 9/18/25 with a load bank to achieve a 30% demand on generator. Identification of others: LTC facility contractor updated preventative maintenance logs with identification of Hospital and LTC Emergency Power guidelines. Systemic Changes: Preventative Maintenance schedule updated to include the emergency and standby power systems testing every 36 months for four-hour load bank testing. Monitoring: Plant ops or designee will audit preventative maintenance schedule monthly and report to the QAPI committee.	09/18/2025

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K0918 SS = D	Continued from page 13 available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 110, Life Safety Code. Failure to provide the required inspection, testing, and maintenance of emergency power systems could lead to injury or death for all residents and staff in the event of an electrical system failure or emergency. The deficiency affected all emergency power systems and could potentially affect all residents, staff, and visitors. The findings were: Document review on 09/17/2025 starting at 8:45 AM revealed the facility's Emergency Power Supply Systems were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following:Level 1 Emergency Power Supply System shall be tested at least once within every 36 months in accordance with the 2010 NFPA 110, section 8.4.9.Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, Section 6.4.4.1, and 2010 NFPA 110, Section 8.4.9	K0918		
K0920 SS = D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used	K0920	Corrective Action: Power strips in patient care vicinity will only be used for components of moveable patient-care-related electrical equipment assembles that have been assembled by qualified personnel. Power cords identified in room 1213 were removed from use on 9/17/25.	10/16/2025

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K0920 SS = D	Continued from page 14 for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide power strips in accordance with 2012 NFPA 99, Health Care Facilities Code. The use of power cords that are not in compliance with 2012 NFPA 99, could increase the risk of electrical failure resulting in injury or death. The deficiency could impact all residents and staff within the affected smoke compartment. The findings were: Observation on 09/17/2025 at 11:58 PM in room 1213 revealed multiple power cords daisy-chained together. All power strips shall be used with general caution. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed. Power strips used in non-patient care areas shall be UL rated. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99, 10.2.3.6, 10.2.4	K0920	Continued from page 14 Identification of others: Facility wide review for power cords completed 9/16/25. Systemic Changes: All staff education to be perfomed 10/9/25 on electrical safety policies. Resident education to be provided 10/16/25 in Resident Council on electrical safety policies. Monthly safety sweep initiation to identify extension cords and splitters. Monitoring: monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	
K0923 SS = E	Gas Equipment - Cylinder and Container Storag	K0923	Corrective Action: Oxygen Storage areas will be equipped with required regulatory language. Installed	10/06/2025

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K0923 SS = E	Continued from page 15 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 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide the required precautionary signage on the doors leading to the oxygen storage rooms in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to provide the required precautionary signage could increase the risk of fire ignition leading to injury or death in the case of a	K0923	Continued from page 15 required language signs on oxygen storage doors 10/6/25. Identification of others: Facility wide inspection of all oxygen and compressed gas storage area conducted 9/16/25. Systemic changes: Updated monthly safety sweep to include missing signs or damage to walls. Monitoring: monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	

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K0923 SS = E	Continued from page 16 fire. The deficiency affected all liquid oxygen storage rooms in the facility, on the 1st and second floors and could potentially affect all residents, staff, and visitors. The findings were: Observation on 09/16/2025 at starting at 9:38 AM revealed the door to the oxygen storage room 286F included a sign stating "Oxygen Storage" and "Caution Flammable", but it was missing the required regulatory language in accordance with 2012 NFPA 99 section 11.3.4.2. The language was shared with the remaining oxygen storage rooms on the 1st and 2nd floors. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99 Section 11.3, 11.3.4, 11.3.4.2	K0923		
K0927 SS = F Bldg. 01	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide areas for transfilling liquid oxygen in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to provide areas for transfilling liquid oxygen in accordance with the 2012 NFPA 99, Health Care Facilities Code could increase the risk of fire resulting in injury or death. The deficiency could affect all staff using the	K0927	Corrective Action: Oxygen Transfilling areas will be equipped with required regulatory language. Installed required language signs on oxygen storage doors 10/6/25. Identification of others: Facility wide inspection of all oxygen transfilling areas conducted 9/16/25. Systemic Changes: Updated monthly safety sweep to include missing signs or damage to walls. Monitoring: monthly review of safety sweep compliance and concerns. Report monthly to QAPI committee.	10/06/2025

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K0927 SS = F Bldg. 01	Continued from page 17 transfilling rooms. The deficiency affected all liquid oxygen transfilling rooms in the facility. The findings were: Observation on 09/16/2025 at 9:40 AM revealed room 286F was used for transfilling liquid oxygen. Further observation revealed the room was not provided with signage indicating that smoking in the area is not permitted in accordance with the 2012 NFPA 99, Health Care Facilities Code section 11.5.2.3. Further observations beginning at 11:05 AM revealed additional rooms used for transfilling liquid oxygen were also lacking the signage indicating that smoking in the immediate area is not permitted including: 1. Room 129G 2. Room 145 3. Room 177G 4. Room 038 5. Room 035 Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency. REF: 2012 NFPA 99 Section 11.5.2.3	K0927		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 09/16/2025 and 09/17/2025. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E0000		09/25/2025
E0041 SS = F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The	E0041	Corrective Action: Four-hour generator testing for emergency and standby power systems was completed on 9/18/25 with a load bank to achieve 30% demand on generator. Identification of Others: LTC facility contractor updated preventative maintenance logs with identification of Hospital and LTC Emergency Power guidelines. Systemic Changes: Preventative Maintenance schedule updated to include the emergency and standby power systems testing every 36 months for four-hour load bank testing. Monitoring: Plant ops or designee will audit preventative maintenance schedule monthly and report to the QAPI committee.	09/18/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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E0041 SS = F	Continued from page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014.	E0041		

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The Legacy Living and Rehabilitation Center	**1000 S Douglas Way , Gillette, Wyoming, 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
E0041 SS = F	Continued from page 2 (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the 2012 NFPA 99, Health Care Facilities Code, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems, in accordance with §483.7(e)(2). Failure to provide the required inspection, testing, and maintenance of emergency power systems could lead to injury or death for all residents and staff in the event of an electrical system failure or emergency. The findings were: Document review on 09/17/2025 starting at 8:45 AM revealed the facility's Emergency Power Supply Systems were not tested and maintained in accordance with the 2010 NFPA 110 Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Healthcare Facilities Code. Document review revealed the facility failed to provide evidence of the following:Level 1 Emergency Power Supply System shall be tested at least once within every 36 months in accordance with the 2010 NFPA 110, section 8.4.9.Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of the observation acknowledged the deficiency. Interview with the facility administrator, facility director, facility manager, and the emergency management coordinator at the time of exit confirmed the deficiency.	E0041		