DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| 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 03/12/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Legacy Living and Rehabilitation Center | 1000 S Douglas Way , Gillette, Wyoming, 82716 |

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| K0000 | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/11/2026 through 03/12/2026.<br><br>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.<br><br>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 72 residents. The findings that follow demonstrate noncompliance with 42 CFR 48.90. | K0000 | | 03/27/2026 |
| K0100<br>SS = D | General Requirements - Other<br><br>CFR(s): NFPA 101<br><br>General Requirements - Other<br><br>List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to maintain ceiling systems in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms, and could potentially affect residents, staff, and visitors in the area. The findings were:<br><br>Observation on 03/11/2026 at 2:40 PM in room 118, | K0100 | Corrective Action:<br><br>The displaced ceiling tile in room 118 (Nutrition Storage) was immediately repositioned and secured in the ceiling grid on 3/11/26. The ceiling system was inspected to ensure proper placement and integrity was restored.<br><br>Corrective Action for Others<br><br>A facility-wide audit of ceiling tiles in all accessible areas was completed on 3/11/26 to identify any additional displaced, missing, or damaged tiles. Any identified issues were found.<br><br>Systemic Changes to Prevent Recurrence<br><br>Staff education during safety sweeps for ceiling system integrity . Audit above ceiling permits are completed in its entirety and compliance is restored. | 04/08/2026 |

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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| K0100<br>SS = D | Continued from page 1<br>Nutrition Storage, found a ceiling tile that had been pushed out of the ceiling grid and over to allow access to a damper. It had not been replaced upon completion of the damper inspection.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>Ref: 2012 NFPA 101: Section 19.1.1.1.3, 4.6.12.1 | K0100 | Continued from page 1<br>Monitoring to Ensure Ongoing Compliance<br><br>Weekly audit x 4, then monthly x 3. Results will be taken to QAPI committee | |
| K0223<br>SS = E | Doors with Self-Closing Devices<br><br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br><br>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:<br><br>* Required manual fire alarm system; and<br><br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>* Automatic sprinkler system, if installed; and<br><br>* Loss of power.<br><br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br><br>This STANDARD is NOT MET as evidenced by:<br><br>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 four (4) of multiple doors and could potentially affect all residents, staff, and visitors. | K0223 | Corrective Action<br><br>The four (4) identified cross-corridor smoke barrier doors (TCF2 #2, #1300-1, #1400-1, and TCF1 #B) were adjusted and repaired on 3/11/26 to ensure proper self-closing and positive latching. Each door was tested and verified to fully close and latch when released.<br><br>Corrective Action for Others<br><br>A facility-wide audit of all smoke barrier, fire-rated, hazardous area, and cross-corridor doors was completed on 3/11/26 to ensure proper self-closing and latching. Any identified doors not functioning properly were immediately adjusted or repaired to ensure compliance.<br><br>Systemic Changes to Prevent Recurrence<br><br>Staff education on fire and smoke door latchings for self-closing doors. Safety Sweeps monthly throughout facility to include self-latching doors to prevent the spread of smoke and fire.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Test 5 random doors 1 x weekly x 4 weeks, then monthly x 3 months. Findings will be taken to QAPI committee monthly. | 04/08/2026 |

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| K0223<br>SS = E | Continued from page 2<br>The findings were:<br><br>Observations on 03/11/2025 at starting at 10:20 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:<br><br>1. Cross corridor rated fire doors TCF2 #2 failed to latch at 10:20 AM<br><br>2. Cross corridor rated fire doors # 1300-1 failed to latch at 11:24 AM<br><br>3. Cross corridor rated fire doors #1400-1 failed to latch at 12:01 PM<br><br>4. Cross corridor rated fire doors TCF1 #B failed to latch at 2:30 PM<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7.1, 7.2.1.8 | K0223 | | |
| K0271<br>SS = D | Discharge from Exits<br><br>CFR(s): NFPA 101<br><br>Discharge from Exits<br><br>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.<br><br>18.2.7, 19.2.7<br><br>This STANDARD is NOT MET as evidenced by:<br><br>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 one (1) of multiple exit discharges from the building's rear, and | K0271 | Corrective Action<br><br>Exit discharge from stairwell #4 was cleared of all ice and snow on 3/11/26<br><br>Corrective Action for Others<br><br>All exit discharges evaluated for means of egress for snow, ice, or other obstructions was completed on 3/11/26 with no additional findings.<br><br>Systemic Changes to Prevent Recurrence<br><br>Grounds will assist plant ops with snow removal during times of heavy snow or decreased staff.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Walk 4 discharge exits from facility 1 x weekly x 4 weeks, then monthly x 3 months. Findings will be taken to QAPI committee monthly. | 03/12/2026 |

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| K0271<br>SS = D | Continued from page 3<br>could potentially affect all residents, staff, and visitors. The findings were:<br><br>Observation on 03/11/2026 at 2:34 PM at the exit discharge from stairwell #4 revealed the sidewalk was covered in a snow and ice mixture, leaving a slick walking surface to traverse to the public way.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.2.1, 19.2.7, 19.7.3.1; 7.1.10.1, 7.1.6.4 | K0271 | | |
| K0321<br>SS = D | Hazardous Areas - Enclosure<br><br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br><br>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.<br><br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br><br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br><br>a. Boiler and Fuel-Fired Heater Rooms<br><br>b. Laundries (larger than 100 square feet)<br><br>c. Repair, Maintenance, and Paint Shops<br><br>d. Soiled Linen Rooms (exceeding 64 gallons)<br><br>e. Trash Collection Rooms | K0321 | Corrective Action<br><br>The mechanical room 101N door was repaired on 4/6/26 to include a properly functioning self-closing device. The door was tested and verified to fully close and positively latch. All identified wall penetrations within mechanical room 101N were sealed/repaired using approved fire-rated materials to restor the 1-hour fire barrier integrity.<br><br>Corrective Action for Others<br><br>Reviewed all hazardous area enclosures have closure devices and sealed penetrations on 3/11/26, no additional findings.<br><br>Systemic Changes to Prevent Recurrence<br><br>Updated the above ceiling fire penetration PM to include all rated walls monthly.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Audit 1 neighborhood weekly x 4 weeks, then monthly x 3 months. Findings will be taken to QAPI committee monthly. | 04/06/2026 |

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| K0321<br>SS = D | Continued from page 4<br><br>(exceeding 64 gallons)<br><br>f. Combustible Storage Rooms/Spaces<br><br>(over 50 square feet)<br><br>g. Laboratories (if classified as Severe<br><br>Hazard - see K322)<br><br>This STANDARD is NOT MET as evidenced by:<br><br>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 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 in the area. The findings were:<br><br>Observation on 03/11/2026 at 2:21 PM revealed the mechanical room 101N, in the admin area, did not have a door closure on the door. Further observations revealed the room to have a 1-hour rating, with a rated door. It was noted that the room had several penetrations that were unsealed, or the sealed penetration had degraded.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.3.2.1, 19.3.2.1.3, 8.7, 8.3, 8.3.5 2010 NFPA 80 Sections, 5.2.4.2 (1), 6.1.4.2.1 | K0321 | | |
| K0325<br>SS = D | Alcohol Based Hand Rub Dispenser (ABHR)<br><br>CFR(s): NFPA 101<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br><br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br><br>* Corridor is at least 6 feet wide | K0325 | Corrective Action<br><br>EVS room, #005, had 4 cases of hand santizer removed to obtain findings below 10 gallons of Class 1 Liquid<br><br>Corrective Action for Others<br><br>Reviewed alcohol based hand rub storage throughout facility with no additional findings on 3/11/26 | 04/09/2026 |

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| K0325<br>SS = D | Continued from page 5<br><br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br><br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br><br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room<br><br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30<br><br>* Dispensers are not installed within 1 inch of an ignition source<br><br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br><br>* ABHR does not exceed 95 percent alcohol<br><br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br><br>* ABHR is protected against inappropriate access<br><br>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to store Alcohol-Based Hand-Rub (ABHR) in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 30, Flammable and Combustible Liquids Code . Failure to store ABHR as required could contribute to the spread of smoke or fire, resulting in injury or death during an emergency. The deficiency affected one (1) of several storage rooms in the facility, and could potentially affect residents, staff, and visitors within the smoke compartment. The findings were<br><br>Observation on 03/11/2026 at 4:20 PM in the EVS room, #005, revealed that there was 48L (12.7 Gallons) of ABHR. The room was rated 1-hour, and had a 3/4 hour-rated door. However, the control area was also below the grade plane in the basement. ABHR is considered a Class 1 liquid, and as such is not permitted in basement storage locations. | K0325 | Continued from page 5<br><br>Systemic Changes to Prevent Recurrence<br><br>Staff education to ensure amoung inside EVS store room or any smoke compartment does not exceed 10 gallons. Transitioned suppliers with smaller volume containers<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Audit 3 alchohol based hand rub storage spaces weekly x 4 weeks, then monthly x 3 months. Findings will be taken to QAPI committee monthly. | |

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| K0325<br>SS = D | Continued from page 6<br>2012 NFPA 30 definition of basement "For the purposes of this code, a story of a building or structure having one-half or more of its height below ground level and to which access for fire-fighting purposes is restricted."<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101: Section 19.3.2.3(7)<br><br>2012 NFPA 30 Sections 3.3.4, 9.3.6, 9.6.2.1(7), 9.7.1, 9.7.2, 9.7.3 Tables 9.6.2.1, 9.7.2 | K0325 | | |
| K0353<br>SS = D | Sprinkler System - Maintenance and Testing<br><br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br><br>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.<br><br>a) Date sprinkler system last checked<br>_____________________<br><br>b) Who provided system test<br>____________________________<br><br>c) Water system supply source<br>__________________________<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br><br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, document review and staff interview, the facility failed to maintain 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 | K0353 | Corrective Action<br><br>Room 2207 entryway sprinkler head and escutcheon was replaced 3/18/26. Fire alarm cabeling above the ceiling in 2319 was fixed and removed from sprinkler system piping on 3/11/26.<br><br>Corrective Action for Others<br><br>All other sprinklers and escutcheon evaluated and no additional findings on 3/11/26<br><br>Systemic Changes to Prevent Recurrence<br><br>Staff education on sprinkler heads are in compliance during safety sweeps. Ensure above ceiling permits are being filled out and verify areas are where work was completed are put back in compliance.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Weekly audit x 4, then monthly x 3. Results will be taken to QAPI committee | 03/18/2026 |

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| K0353<br>SS = D | Continued from page 7<br>of Water-Based Fire Protection Systems. Failure to maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency impacted the immediate location of each observation, as well as the adjacent corridor. The deficiency could affect all residents, staff, and visitors in the affected smoke compartment. The findings were:<br><br>1. Observation on 03/11/2026 at 10:04 AM in room 2207 revealed the entryway sprinkler had an encrustation of unknown origin encasing the bulb and parts of the sprinkler head. When the encrustation was was scraped nothing was able to be removed.<br><br>Interview with the facility maintenance and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Sections 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4<br><br>2. Observation on 03/11/2026 at 11:06 AM revealed fire alarm cabling resting on fire sprinkler system piping above the ceiling near room 2319. Sprinkler piping shall not be subjected to external loads by materials resting on pipe or hung from pipe.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Sections 5.2.2.2 | K0353 | | |
| K0511<br>SS = D | Utilities - Gas and Electric<br><br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br><br>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. | K0511 | Corrective Action<br><br>The deep fryer in the kitchen had a restraint placed to protect the flexible gas piping when the appliance on 3/18/26. The appliance was tested to ensure safe operation and proper restraint when moved.<br><br>Corrective Action for Others<br><br>All gas-fired equipment was evaluated and no additional | 04/09/2026 |

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| K0511<br>SS = D | Continued from page 8<br><br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to protect gas-fired equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2012 NFPA 54, National Fuel Gas Code. Failure to protect gas-fired equipment could lead to system damage and failure, resulting in injuries to staff or residents. The deficiency affected the kitchen, and all staff working within. The findings were:<br><br>Observation on 03/11/2026 at 3:45 PM in the kitchen revealed gas-fired cooking appliances. Further observation revealed that the appliances were on casters, and the cook-top was provided with the required restraint to protect the flexible gas piping when the appliances are moved for service or cleaning. However, the deep fryer did not have a restraint to protect the flexible gas piping when the appliance was moved.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.5.1.1; 9.1.1<br><br>2012 NFPA 54, Section 9.6.1.2 | K0511 | Continued from page 8<br>findings on 3/11/26<br><br>Systemic Changes to Prevent Recurrence<br><br>Staff education on ensuring all gas fired equipment has tethers attached. Gas-fired appliances added to HACCP monthly audit log.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Weekly audit x 4, then monthly x 3. Results will be taken to QAPI committee | |
| K0531<br>SS = E | Elevators<br><br>CFR(s): NFPA 101<br><br>Elevators<br><br>2012 EXISTING<br><br>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record.<br><br>Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, | K0531 | Corrective Action<br><br>The elevator Firefighter Recall System (Phase I and Phase II), which operates on a centralized control system serving all four (4) elevators, was tested on 3/31/2026. Successful operation was verified for all elevators, and documentation was completed<br><br>Corrective Action for Others<br><br>The centralized elevator control system serving all four (4) elevators was reviewed for compliance. A retrospective audit of testing logs for the previous 6 months was completed on 3/31/2026 to ensure required monthly Firefighter Recall testing was completed. | 03/31/2026 |

| 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 **03/12/2026** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| K0531<br>SS = E | Continued from page 9<br>conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)<br><br>19.5.3, 9.4.2, 9.4.3<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to maintain elevators in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain elevators as required could result in injury or death during an emergency. The deficiency affected four (4) of four (4) elevators, and could potentially affect all residents, staff, and visitors. The findings were:<br><br>Document review on 03/12/2026 starting at 8:00 AM revealed that the required monthly testing of the elevator fire fighter recall system had not been completed in full. Recorded dates had listings for quarterly inspection including February of 2026 as the most recent.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>Ref: 2012 NFPA 101: Sections: 19.5.3, 9.4.6.2, 4.6.12.1, 4.6.12.4 | K0531 | Continued from page 9<br>Systemic Changes to Prevent Recurrence<br><br>Update PM schedule to reflect the monthly requirement. Education to Plant Ops staff on requirements of test and frequency.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Weekly audit x 4, then monthly x 3. Results will be taken to QAPI committee monthly | |
| K0771<br>SS = F<br><br>Bldg. 01 | Engineer Smoke Control Systems<br><br>CFR(s): NFPA 101<br><br>Engineer Smoke Control Systems<br><br>2012 EXISTING<br><br>When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.<br><br>19.7.7<br><br>This STANDARD is NOT MET as evidenced by: | K0771 | Corrective Action<br><br>Immediate contact with qualified, licensed fire protection vendor was completed to schedule inspection and testing of the engineered smoke control system serving the atrium. Testing of the smoke control system is scheduled to be completed by 4/25/26, in accordance with recognized engineering principles consistent with regulations. Documentation of the inspection, testing results, and system performance will be obtained and maintained ons-site in the Life safety Compliance Binder.<br><br>Corrective Action for Others | 04/25/2026 |

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| K0771<br>SS = F<br><br>Bldg. 01 | Continued from page 10<br><br>Based on document review and staff interview, the facility failed to provide evidence of maintenance and testing of engineered smoke control systems in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide maintenance and testing of engineered smoke control systems could lead to injury or death in the event of a fire. The deficiency affected the atrium engineered smoke control system. The deficiency could affect all residents, staff, and visitors in the facility.<br><br>Documentation review on 03/12/2026 beginning at 8:00 AM revealed the facility failed to provide evidence of maintenance and testing of the engineered smoke control system for the atrium in accordance with the 2012 NFPA 101, Section 8.6.7, and 19.7.7.1. All existing engineered smoke control systems shall be tested in accordance with recognized engineering principles, per 2012 NFPA 101, Section 19.7.7.1. Test documentation shall be maintained on the premises at all times. 2012 NFPA 92 is a document that provides recognized engineering principles for the testing of smoke control systems as noted in 2012 NFPA 101 Section A19.7.7, but other references maybe utilized.<br><br>Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.7.7.1, 8.6, 8.6.7<br><br>2012 NFPA 92, Standard for Smoke Control Systems | K0771 | Continued from page 10<br>The Maintenance supervisor conducted a review of all Life Safety systems on 03/13/2026, including fire alarm, sprinkler, and any additional systems requiring routine testing, to ensure required inspections, testing, and documentation are current and maintained on-site. No additional disficient practices were identified.<br><br>Systemic Changes to Prevent Recurrence<br><br>Set PM up to schedule testing and activation. Facility will contract with qualified vendor to perform ongoing annual testing of the engineered smoke control system. All required documentation will be maintained in a centralized Life Safety Code Binder(s) and will be readily available for review.<br><br>Monitoring to Ensure Ongoing Compliance<br><br>Matintenance Supervisor will conduct monthly audits of the Life Safety binder to ensure all required inspection and testing documentation is current and complete. PM schedule will be reviewed monthly to ensure all PM's were completed. Results of audits will be reported to the Quality Committee monthly . | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| **STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS** | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **535022** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED **03/12/2026** |
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| E0000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on 03/11/2026 through 03/12/2026. Based upon the findings of the survey, it was determined the facility was in compliance with all requirements of 42 CFR 483.73. | E0000 | | 03/27/2026 |

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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