STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 10/19/2017

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 10/16/17 through 10/19/17. Also reviewed in the course of the survey were complaint intakes WY000002430 and WY000002439.	F 000		
F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of	F 166		12/3/17

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

Electronically Signed | 11/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 1 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not	F 166		

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F 166	Continued From page 2 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of grievances, policy review, and staff interview, the facility failed to ensure grievances were fully addressed to ensure resolution for 1 of 3 grievances reviewed. In addition, the facility failed to develop the policy and procedure for grievances to include specific requirements. The findings were: 1. Review of a grievance dated 9/24/17 from resident #31 showed the resident had several areas of concern including dietary/food, nurse staffing, and dignity. Review of the information including the resolution letter sent to the resident dated 10/17/17 showed it failed to address areas other than dietary. 2. Review of the "Patient Grievance Policy" approved 1/19/16 showed the procedure included that "All grievances will be reported to the Patient and Resident Experience staff and acknowledged	F 166	Correction for cited residents: Grievance Resolution letter revised to include all issues related to Resident #31 to include dietary, food, nurse, staffing and dignity. Patient grievance policy revised to include specific LTC related regulatory requirements to include identification of a Grievance Official, to include his/her name, business addresses (mailing and email),and business phone number. Also to include the contractor information of independent entities with whom grievances may be filed including the State Survey Agency and Long Term Care Ombudsman or Protection and Advocacy System. Identification of other residents:	

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F 166	Continued From page 3 in writing within seven calendar days. If the grievance cannot be resolved within seven days, the complainant will be contacted..." The policy failed to identify a grievance official and specify the contact information of the grievance official to include his/her name, business addresses (mailing and email) and business phone number. The policy further failed to include the contact information of independent entities with whom grievances may be filed including the State Survey Agency and Long-Term Care Ombudsman, or protection and advocacy system. 3. Interview with the administrator on 10/18/17 at 3:30 PM verified the policy was in need of updating and the feedback to resident #31 failed to cover all of the identified areas of concern.	F 166	All residents have the potential to be affected by unresolved grievances and inadequate information to file a grievance. Systematic changes and Monitoring: 1. Resident Grievance policy to be reviewed and revised in accordance with regulations. 2. Grievance Official to perform staff education related to filing grievances, resolution of grievances and Grievance Official contact information. 3. New employee orientation to be revised to include grievance process and policy. 4. Revision of dashboard to reflect completion of grievances per policy. Outcome: 1. Grievances will be completed and resolved promptly, within timelines identified within policy. Grievances will be completely addressed in resolution letter. 2. Grievance official or designee will collect data from quarterly audit with discrepancies investigated and resolved. Data will be aggregated on dashboard and reported quarterly at long term care Quality Meetings and semiannually at organizational Quality Meetings with action plans as appropriate.	
F 167 SS=B	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State	F 167		12/3/17

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F 167	Continued From page 4 surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a notice indicating the availability of surveys for the preceding 3 years was posted as required. The resident census was 148. The findings were: Observation on 10/17/17 at 1:18 PM showed a binder placed at the reception area contained the most recent health survey and life safety code survey. Further observation showed there was no notice posted to let individuals know that survey results from the previous 3 years were available for review upon request. Interview with the administrator on 10/19/17 at 12:15 PM confirmed	F 167	Correction for cited residents: Facility notification board has been updated with information regarding how to request reports with respect to any surveys, certifications and complaint investigations made respecting the facility during the 3 preceding years and any plan of correction in effect with respect to facility for any individual to inspect. The posting includes notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	

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F 167	Continued From page 5 there was no such notice posted.	F 167	Identification of other residents: All residents have the potential to be affected by required postings not being accessible. Systematic changes and Monitoring: 1. Audit of regulations will be conducted annually to ensure all required posting are posted and accessible to residents and visitors. 2. Administrator or designee will conduct Staff education regarding mandatory postings and location of postings. Outcome: 1. Required postings will be posted in the facility and available for residents, visitors and staff to visualize or request information. 2. Administrator or designee will collect data from annual audit with discrepancies investigated and resolved. Data will be aggregated on dashboard and reported annually at long term care quality meetings with action plans as appropriate.	
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and review of scheduled meal times,	F 241	Correction for cited residents: Resident #78 meal served at 5:56pm,	12/3/17

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F 241	Continued From page 6 the facility failed to ensure the dining process maintained or enhanced quality of life for residents on 2 of 5 units observed (Birch and Pine). The census of these units was 59. The findings were: 1. Review of the Meal Service Schedule, updated on 12/2/16, showed each unit was scheduled for meals at the same time. The evening meal time was scheduled to begin at 5 PM. 2. Observation of the evening meal on 10/16/17 showed the steam table arrived to the Birch unit at 5:18 PM. The first resident was served at 5:27 PM. The following concerns were identified: a. Observation at 5:33 PM showed the table mate of resident #78 was served. Continued observation at 5:55 PM showed resident #78 turned to ask the staff "Why haven't we got no dinner yet?" The resident's order was taken at 5:56 PM. b. Observation at 6:03 PM showed resident #103 wheeled him/herself away from the dining room down the hall. Interview at that time revealed the resident was not feeling well and did not have dinner. When asked if s/he ordered food, the resident replied "They were busy so I didn't eat." c. Observation at 6:12 PM showed the final resident in the dining room was served, 45 minutes after the first resident was served and 72 minutes after the meal was scheduled to start. 3. Observation on 10/16/17 at 5:13 PM in the Pine dining room showed the food cart arrived and 10 residents were seated in the dining room waiting for the evening meal. The dietary server was taking the residents' orders, preparing the plates, and delivering the plates to the residents.	F 241	meal service to start at 5:00 pm, table mate served at 5:33 pm. Unable to resolve this late meal service serving. Meal service to be served per policy and per menu unless requested otherwise. Resident #103 left dining room at 6:03 pm stating staff were too busy. Resident refused dinner per documentation in medical record. Unable to resolve this late meal service serving. Meal service to be served per policy and per menu unless requested otherwise. 6:12 pm last resident served in the dining room, 45 minutes after the first served and 72 minutes post meal service time. Unable to resolve this late meal service serving. Meal service to be served per policy and per menu unless requested otherwise. Residents #53 and #60 received meal at 5:58 pm when steam cart arrived on Pine at 5:13 pm. Residents had been sitting there since 5:13 pm. Unable to resolve this late meal service serving. Meal service to be served per policy and per menu unless requested otherwise. Identification of other residents: All residents have the potential to be affected by delayed meals, cold meals, and residents leaving table prior to initiating or finishing meal service. This results in cold food and residents leaving table prior to finishing meal, potential for weight loss and malnutrition as well as resident dignity and satisfaction.	

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F 241	Continued From page 7 At 5:48 PM dietary supervisor #1 came into the dining room to assist with getting orders taken and meals delivered. At that time she took the orders of residents #53 and #60 who had been waiting since the food cart arrived. The meals were delivered to residents #53 and #60 at 5:58 PM, 58 minutes after the scheduled meal time began. 4. Interview on 10/19/17 at 8:54 AM with the certified dietary manager and the nutrition services supervisor revealed the meal service process needed to be improved. There were plans to have the process evaluated by a professional group for recommendations. The manager verified the length of time these resident waited for their meals was not acceptable.	F 241	Systematic changes and monitoring: 1. Meal service policies will be reviewed and revised as necessary to ensure resident satisfaction and proper meal serving. 2. Resident quality of life policy reviewed and revised to include resident rights regarding menu choices and dining. 3. Dietitian, Nutrition Supervisor, and Director of Nursing will provide staff education related to provision of meals per policy. 4. Toyota directed LEAN quality project related to food service, first meeting November 2, 2017. 5. Nutrition leadership rounding during meal times to ensure adherence to policy regarding meal times, service and temp monitoring. 6. Develop audit tool to collect timeliness of meal delivery. Outcome: 1. Residents will be served within designated time frames per policy with measures identified on facility quality dashboard. 2. Nutrition supervisor or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate. Once outcome is met, data collection and aggregation will occur quarterly and reported quarterly.	

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F 248	Continued From page 8	F 248		
F 248 SS=E	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interview and review of the activities calendar, the facility failed to provide an adequate weekend activity program for 2 of 2 months reviewed (September 2017, October 2017). The findings were: Interview on 10/17/17 at 3 PM with a group of residents revealed they had concerns with facility activities provided on the weekends. Of the 10 residents present, 5 residents agreed that "weekends are the worst" and they would like more activities. They stated they were concerned that the only activities offered on weekends were "nail care and church." Interview on 10/18/17 at 3:38 PM with resident #48 and a family member revealed they wished there were more activities. The family member stated "All they [the residents] have is activities and food" and it was hard for the activities staff to provide adequate activities for the entire facility as	F 248	Correction for cited residents: Resident #48 and family member follow up regarding concerns related to activities and to identify requested activities. Care plan updated to reflect current interests. Activity assessment results reviewed to determine current activity offerings are consistent with resident interests throughout the week also to include weekends. Identification of other residents: All residents have the potential to be affected by social isolation resulting in depression, isolation, boredom, falls, functional decline, and behaviors. Systematic changes and monitoring: 1. Review of current activity offerings and calendars.	12/3/17

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F 248	Continued From page 9 they were currently down 2 activity assistants. Review of the activity calendars for September and October 2017 showed Sunday activities included several church services. Saturday activities included nail care and mail pass weekly, and a "History" activity offered 1 time each month. Interview with the activities director on 10/19/17 at 10:36 AM revealed the activities staff was currently down to herself plus 2 assistants, with only 1 staff member working on weekends. She stated they tried to incorporate a variety of activities on the other days of the week to meet resident needs. She said they also relied on volunteers and certified nurse aides to assist with activities.	F 248	2. Staffing review already completed with open position pending interviews. 3. Revision of staffing matrix to accommodate additional staff member to meet resident needs. 4. Develop audit form to collect data related to activity rounding. 5. Administrator newsletter to include current activities to ensure complete comprehension of activities program. 6. Activities coordinator to educate staff on current activities to encourage participation of activities. Outcome: 1. Activities on weekends will be of sufficient diversity to meet the majority of the resident needs. 2. Activity coordinator will collect data from observations/rounding with residents monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meeting with action plans as appropriate. Once outcome is met, data collection and aggregation will occur quarterly and reported quarterly.	
F 368 SS=E	FREQUENCY OF MEALS/SNACKS AT BEDTIME CFR(s): 483.60(f)(1)-(3) (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 368		12/3/17

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F 368	Continued From page 10 (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure bedtime snacks were offered to the residents. The census was 148. The findings were: Interview with a group of residents on 10/10/17/17 at 3 PM revealed the facility made snacks available for residents at all times; however, they stated staff did not pass out or ask residents if they wanted an evening snack. Interview on 10/18/17 at 12:24 PM with the nutrition services supervisor and the certified dietary manager revealed each unit refrigerator was stocked with snacks daily. They stated the residents were able to request or help themselves to snacks; however, there was no process to ensure all residents were offered or served a snack at bedtime.	F 368	Correction for cited residents: Snacks are available at all times however there is not a process for passing them out at evening snacks time. Unable to remedy the failure to pass evening snacks at the time of survey. Identification of other residents: All residents have the potential to be affected by inadequate snacks or offering of snacks during evening and prolonged time between substantial meals. Systematic changes and monitoring: 1. Policy related to snack provision reviewed and revised as needed. 2. Revision of electronic medical documentation to include snack provision and offerings and refusals. 3. Community kitchen policy reviewed and revised as needed. 4. Develop audit sheet to monitor offering and refusal of HS snack.	

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F 368	Continued From page 11	F 368	5. DON and nutrition supervisor to provide education related to offering an evening snack to residents. Outcomes: 1. Snacks will be offered to residents and documented in medical record, "offered" and "refused." 2. DON or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Once outcome is met, data collection and aggregation will occur quarterly and reported quarterly. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate. Once outcome is met data collection and aggregation will occur quarterly and reported quarterly.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		12/3/17

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F 441	Continued From page 12 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to ensure infection prevention measures were developed and implemented for nebulizer breathing treatments for 1 of 1 sample residents (#31) observed. The following concerns were identified: 1. Observation on 10/10/17 at 12:35 PM showed resident #31 received a nebulizer breathing treatment. Upon completion of the treatment medication assistant (MA-C) #1 placed the mask and medication cup into a plastic bag without rinsing. 2. Interview with registered respiratory therapist #1 on 10/19/17 at 12:20 PM revealed the expectation was for the nebulizer medication cup to be shaken, inspected and left to open air after each use. 3. Review of the infection prevention policy and procedure "Guidelines for Cleaning Equipment in Cardiopulmonary Services" dated October 23, 2016 showed small volume nebulizers were to be "emptied after each use and changed as needed to include masks as needed." These guidelines failed to include further details related to cleaning	F 441	Correction for cited residents: Resident #31 nebulizer cleaned per revised policy. Identification of other residents: All residents have the potential to be affected by inappropriate cleaning of nebulizer medication cup resulting in potential contamination or infection. Systematic changes and monitoring: 1. Policy and processes related to respiratory medication administration cleaning device will be reviewed and revised as needed and literature reviewed related to evidence based practice. 2. Develop audit tool to observe adherence to policy for cleaning nebulizer medication containers and report on long term care quality dashboard. 3. Respiratory therapy/infection prevention to provide staff education on cleaning practices related to medication administration devices. Outcomes: 1. Medication administration devices will	

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F 441	Continued From page 14 the equipment between uses. 4. Interview with the infection prevention RN on 10/18/18 at 10:08 AM confirmed the policy did not include instructions for cleaning equipment between uses. 5. Review of the PDR 2013 Edition Nurse's Drug Handbook (pg 326) showed nebulizers should be cleaned after use. 6. According to the American Lung Association (www.lung.org/lung-health-and-diseases/lung-disease-lookup/copd/diagnosing-and-treating/how-to-use-a-nebulizer.html, retrieved 10/20/17) instructions to clean nebulizer equipment included, "Wash the medicine cup and mouthpiece in warm soapy water and rinse. Shake off excess water and let the pieces air dry..."	F 441	be cleaned per policy and procedure. 2. Respiratory therapist will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meeting. Once outcome is met data collection and aggregation will occur quarterly and reported quarterly with action plans as appropriate.	