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 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 7/17/19 through 7/18/19 at The Legacy Living and Rehabilitation Center in Gillette, Wyoming. The survey was prompted by complaint intake WY00002874.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility incident reports and documentation, medical record review, staff interview and family interviews, and review of policy and procedures, the facility failed to ensure residents were free from abuse for 1 of 7 sample residents (#3) reviewed for allegations of abuse. This failure resulted in harm to resident #3, who sustained bruising. The findings were: 1. Review of the 6/12/19 progress notes on resident #3 showed medical history that included chronic depression with anxiety, post-traumatic	F 600	Immediate Corrective Action: Resident #3: implemented actions as defined by abuse and neglect policy to include notification of the follow agencies: staff suspension, physician and family notification, notification of law enforcement, and nursing assessment. Facility investigative team utilized several strategies to investigate allegation of abuse including, interviews, medical director communication, care conference with family, security footage review,	8/11/19

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

Electronically Signed | 08/09/2019

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F 600	Continued From page 1 stress disorder, Alzheimer's type dementia, and spinal stenosis. Review of the significant change Minimum Data Set (MDS) assessment dated 6/24/19 showed a brief interview for mental status (BIMS) score of 0 (indicating the resident was severely cognitively impaired), and further showed the resident required extensive assistance with activities of daily living. The resident was also coded as having behaviors that included verbal behaviors and rejection of care. The following concerns were identified: a. Review of the incident report submitted to the State Survey Agency on 7/1/19 showed the following: i. An allegation of physical abuse was reported by CNA #3 on 7/1/19 at approximately 10 PM. The facility's investigation showed CNA #3 and CNA #4 were in the resident's room performing resident care. CNA #4 "grabbed [the resident] by each shoulder with her hands, and she pushed [the resident's] shoulders down onto the mattress forcefully and said, 'I'm not doing this today.'" The CNA had her left knee on the bed while holding down the resident. Shortly after doing housekeeping duties in the room CNA#4 again went to the bed and "held both sides of the blanket over [the resident's] upper arms, leaned over [the resident], pushing [the resident] down briefly while saying 'I'm not doing this today.'" CNA #3 was unsure what prompted CNA #4 to come back to bedside as no assistance was needed. Both CNAs then left the room. ii. CNA #4 was interviewed by the facility and stated the resident was very active that night before putting him/her to bed, and she had to redirect the resident. In the attempt to redirect, the CNA stated the resident started to hit her so she grabbed the resident's wrist to stop him/her from hitting. The CNA stated she told the	F 600	physical assessments, and medical record review. Identifying other residents who may be affected: All residents have the ability to be affected and have the right to be free from abuse, neglect, and exploitation. Systemic changes put into place: -Upon hire, annual and as needed, employee abuse and neglect education to include recognition, prevention, and reporting. -Validation of all current employee education related to abuse and neglect. -Family Forum education on abuse and neglect recognition, prevention, and reporting for families. -Volunteer education of abuse recognition, prevention and reporting for families. Measuring Effectiveness: -Audit 10 staff per month across all departments (staff, volunteers, contractors) to ensure receipt of abuse and neglect education. -Random audit of retention of information related to abuse and neglect (10 employees per month). -Report to quality quarterly by DON (or designee) with any variance investigated. Outcome: 100% of staff will have evidence of abuse and neglect education. This data will be collected by DON (or designee) and will be aggregated and reported quarterly at long term care quality meeting. All	

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F 600	Continued From page 2 resident, "let's not do this, no hitting tonight." The facility noted the CNA gave conflicting accounts of the incident, and of her care of the resident. iii. Two facility registered nurses completed a full head-to-toe assessment at that time on the resident and found multiple bruised areas: left outer elbow, left forearm, left second finger, right posterior bicep, and right wrist. It was the RNs' opinion that some of the bruises were new, and that some of the bruising did resemble finger print bruising. iv. The facility substantiated abuse, and terminated CNA #4's employment at the facility. b. Interview on 7/18/19 at 9:02 AM with the DON revealed CNA #4 was suspended 25 minutes after the incident occurred. The CNA was relieved of her duties at the facility after the investigation was completed. She further stated it was the facility's expectation that staff treat residents with respect and dignity. She added that all staff and traveling staff were trained on abuse. c. Interview on 7/18/19 at 11 AM with the resident's son and daughter revealed the resident had "bruises all over both arms, and on the upper chest." Further, the son stated the resident had complained to the family that s/he was being handled roughly prior to this incident. d. Interview on 7/18/19 at 11:48 AM with the facility physician revealed he did exam the resident after the incident and noted the resident had older bruising to the left arm and new bruising to the right arm. He stated he only saw the resident's arms, and verified no pictures were taken of the bruising. e. Interview on 7/18/19 at 2:53 PM with CNA #4 confirmed she helped with the resident's care on 7/1/19 around 9:30 PM. The CNA stated she told the resident "we are not going to do this tonight." She stated she tucked the blanket	F 600	discrepancies will be investigated and reported.	

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F 600	Continued From page 3 around the resident's shoulders, but denied harming the resident. 2. Review of the facilities policy "Abuse of a Vulnerable Adult" (undated) showed "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being."	F 600		