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 12/16/2020

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 from 12/15/20 through 12/16/20. The survey was prompted by complaint intakes WY00003031, WY00003115, WY00003131, and WY00003167. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 12/15/20 through 12/16/20. The following common abbreviations are used throughout this document; BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimal Data Set NHA: Nursing Home Administer Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 684	Immediate Actions upon survey findings	2/1/21

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

Electronically Signed | 01/05/2021

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F 684	Continued From page 1 interview, the facility failed to follow physician orders for 2 of 3 residents with a diagnosis of macular degeneration (#16, #39) reviewed. The findings were: 1. Review of the 12/9/20 quarterly MDS assessment showed resident #16 was admitted on 9/13/19, had a BIMS score of 14 out of 15 (cognitively intact), and had a diagnosis of unspecified macular degeneration. The following concerns were identified: a. Review of the 8/25/20 physician progress notes showed "[resident] reports [s/he] is (sic) have not noticed any decline in [his/her] vision ...The patient continues on PreserVision AREDs (eye vitamin and mineral supplement). [His/her] eye disease is significant. Resident has not followed with [name of eye clinic] secondary to the Covid-19 pandemic, and restrictions for visiting and outside appointments here at Legacy. We will add Amsler grid [a diagnostic tool that aids in the detection of visual disturbances caused by changes in the retina] to monitor progression of disease." b. Review of a physician order dated 8/25/20 showed "Complete Amsler grid testing of both eyes with patient every 2 weeks. Please document patient statement in regard to visual changes, distortion, blurry vision, etc." c. Review of the entire medical record showed no evidence the resident's vision had been assessed as ordered by the physician. d. Interview with the DON on 12/16/20 at 5:40 PM revealed the order was incorrectly entered into the electronic medical record and therefore did not show up on the TAR (treatment administration record) for the nursing staff to complete. In an additional interview with the DON and NHA on 12/17/20 at 2 PM confirmed the	F 684	on cited residents: DON identified that discrepancies in provider order entry resulted in the orders not flowing to nursing workflow in the EHR (PCC). Amsler grid order for resident #16 was updated 12/16/20 with new order that flowed to TAR in EMAR portion of PCC. A new order in place at this time for Amsler grid to begin after completion of current erythromycin ointment order. Ointment order completed on 12/22/20. Amsler grid performed on 12/30/20 following original order schedule. No changes in vision noted. Amsler grid order for resident #39 completed on 12/22/20 with new order that flowed to TAR in EMAR portion of PCC. Amsler grid performed with no changes in vision noted. Actions for Systematic Change in Monitoring: 1. January's nursing education topic will cover this deficiency and plan for correction. Emphasis on order entry and verification process so that the nursing task lists (MAR and TAR) are populated appropriately. Staff will have until January 31st to complete the online education which includes knowledge test. 2. By Feb. 1, 2021, 100% of errors in which current provider orders do not flow to nursing task lists will be updated through comprehensive chart review by nursing house supervisors. Nursing house supervisors will inform provider of order update needed and obtain new verbal order. 3. Monthly audits of 10% of resident charts per 40 bed unit will be created by	

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F 684	Continued From page 2 vision test had not been administered to the resident. 2. Review of the 10/23/20 quarterly MDS assessment for resident #39 showed the resident was admitted to the facility on 12/20/2018, had a BIMS score of 15 out of 15 (cognitively intact), and had a diagnosis of unspecified macular degeneration. The following concerns were identified: a. Review of a physician order dated 10/6/20 showed the facility was to complete the Amsler grid per instructions every 14 days. b. Review of the October, November, and December 2020 TAR showed the assessment was completed on 10/21, 11/4, 11/18, and 12/2, however, review of the medical record showed no documentation of the results of the assessment. c. Interview with the DON and NHA on 12/17/20 at 2:05 PM confirmed there was no documentation of the results of the Amsler grid assessment, or communication with the physician.	F 684	January 31, 2021. It will be deployed Feb 1, 2021 and continue through Dec 31, 2021. Monthly order review audits will be completed by nursing house supervisors. 100% of errors identified in the monthly audits will be updated. Nursing house supervisors will inform provider of order update needed and obtain new verbal order. 4. Data will be collected by Administrator/designee to verify resolution of this deficiency and fidelity to the ordering process. 5. By January 31st, education will be provided to providers regarding PCC order entry requirements so that prescribed tasks appear on nursing task lists.	