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 03/09/2023

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 recertification survey was conducted by Healthcare Licensing and Surveys from 3/6/23 through 3/9/23. Also reviewed in the course of the survey was complaint intakes WY000003535. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set MG: milligrams RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		4/21/23

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

Electronically Signed | 03/31/2023

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F 655	Continued From page 1 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and policy review, the facility failed to ensure the baseline care plan was developed within 48 hours of a resident's admission to include the minimum healthcare information necessary to properly care for 1 of 5 sample residents (#311) reviewed. The findings	F 655	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE	

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F 655	Continued From page 2 were: 1. Review of the 2/24/23 admission MDS assessment showed resident #311 was admitted to the facility on 2/20/23 with diagnoses which included right femur fracture, diabetes mellitus, pain, end stage renal disease, and dependent on renal dialysis. The resident had a BIMS score of 13 out of 15, indicating the resident was cognitively intact. Further review showed the resident had a history of falls, required extensive assist with 2 people for transfers and toileting, had a surgical wound, moisture associated skin damage (MASD), used oxygen, and had shortness of breath. The following concerns were identified: a. Observation on 3/6/23 at 3:06 PM showed the resident was lying on a specialty mattress, and oxygen tubing was lying over a bedside lamp while connected to a wall regulator. Interview with the resident at that time revealed s/he had pain due to hip surgery following a fall, used oxygen at night, was diabetic, and had multiple skin issues. S/he further stated s/he had a fistula in the right arm, and received dialysis on every Monday, Wednesday, and Friday. b. Review of the baseline care plan, on 3/7/23 showed the facility failed to identify and implement specific person-centered information needed for dialysis care, and pain management within 48 hours of admission. c. Interview with the DON on 3/8/23 at 4 PM confirmed the facility failed to identify and implement resident-specific health and safety concerns needed to provide care for the resident within 48 hours of admission. 2. Review of the facility policy titled "Care Planning" last reviewed 3/24/22 showed "1. A	F 655	STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. 655 I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The DON/Designee updated the care plan for Resident #311 regarding dialysis services on 3/2/23 and pain management on 3/31/23. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other resident identified on Dialysis services. Audit of all residents identified to have pain management needs. Identified residents' care plans were reviewed and updated as needed to ensure pain	

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F 655	Continued From page 3 base line care plan will be initiated at admission and implemented within 48 hours of admission that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of care."	F 655	management was included on 3/31/23 by the DON/Designee. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to CRC and DON by Vivage Clinical Reimbursement Specialist on 3/13/2023 on Care Planning dialysis services. Education provided to CRCs and Nursing leaders on 3/30 on care planning pain. The nursing department will complete a baseline care plan within 48 hours of admission. The baseline care plan will include the minimum healthcare information necessary to properly care for a residents.The DON/Designee will review baseline care plans within 48 hours of admission to ensure that all areas necessary to properly care for the resident is included in the baseline care plan. The DON/Designee will audit 100% of admissions weekly X 4 weeks and monthly X 2 months to ensure that all necessary information to care for the resident has been identified in the baseline care plan. Any concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:	

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F 655	Continued From page 4	F 655	The DON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed. Date of Compliance: 3/31/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		3/15/23

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F 656	Continued From page 5 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review the facility failed to develop and implement a comprehensive person-centered care plan for 2 out of 25 sample residents (#46 and # 71) reviewed. The findings were: 1. Review of the 2/12/23 quarterly MDS assessment showed resident #46 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact, and had diagnoses which included long term use of anticoagulant (blood thinner) medication. Further review showed the resident received an anticoagulant 7 of 7 days in the look back period. Review of the physician's order summary showed Eliquis (anticoagulant) was ordered and the start date was 10/3/19. Review of the December 2022, January 2023, February 2023, and March 2023 medication administration records (MARs) showed the	F 656	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH	

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F 656	Continued From page 6 resident received Eliquis 5 mg twice per day. The following concerns were identified: a. Review of the care plan last revised on 1/25/23 showed the facility failed to develop a care area for anticoagulant therapy with interventions needed to care for the resident. b. Interview with DON on 3/8/23 at 4 PM confirmed the facility failed to implement care plans related to anticoagulant therapy. 2. Review of the 2/7/23 quarterly MDS assessment showed resident #71 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment, and diagnoses which included long term use of anticoagulants, and atrial fibrillation. Further review showed the resident received an anticoagulant 7 of 7 days in the look back period. Review of the physician's order summary showed Eliquis 2.5 mg was ordered with a start date of 1/9/23. Review of the January 2023, February 2023, and March 2023 MARs showed the resident received Eliquis 2.5 mg twice per day. The following concerns were identified: a. Review of the care plan last revised on 2/27/23, showed the facility failed to develop a care area for anticoagulant therapy with interventions needed to care for the resident. b. Interview with DON on 3/8/23 at 4 PM confirmed the facility failed to implement care plans related to anticoagulant therapy. 3. Review of the facility policy titled "Care Planning" last reviewed on 3/24/22, showed "...5. Care plan goals and objectives are derived from information contained in the resident's comprehensive MDS/ Triggered Care Area Assessments and are defined in the resident's care plan as desired outcome for a specific	F 656	SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. 656 I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #46 and #71 care plans were updated with anticoagulant therapy on 3/15/23. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All other residents were audited on 3/15/23 by the DON to ensure that anticoagulation therapy was included in the plan of care, any identified concerns were addressed. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to CRC and DON by Vivage Clinical Reimbursement Specialist on 3/13/2023 on Care Planning anticoagulation therapy. All medication classes (including anticoagulation therapy) that are coded in Section N should be care planned. CRC should check care plan when coding the MDS. CRC should review care plan with	

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F 656	Continued From page 7 resident problem .... The care plan will be modified accordingly..."	F 656	each MDS assessment to ensure items that are coded on the MDS are care planned appropriately. The CRC/Designee will audit each MDS weekly X 4 weeks and monthly X 2 months to ensure that anticoagulants have been identified in the comprehensive care plan. Any concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The CRC/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed. Date of Compliance: 3/15/23	
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must	F 838		4/23/23

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F 838	Continued From page 8	F 838		

address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and

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F 838	Continued From page 9 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the facility assessment, staff interview, and policy and procedure review the facility failed to review and update the facility assessment at least annually for 1 of 1 facilities. The census was 112. The findings were: 1. Review of the facility assessment showed the facility last completed a facility assessment in October 2021. Further review showed no evidence a facility assessment review and update was completed from October 2021 to March 2023. 2. Interview with the ADON on 3/7/23 at 1:20 PM revealed the most recent facility assessment was completed on October 2021 and she confirmed a facility assessment had not been completed for 2022. 3. Review of the policy and procedure "Facility Assessment" showed "...A Facility assessment will be completed and reviewed annually for [long term care] LTC... ...7. An annual inventory of resources will be completed to ensure the facility resources are adequate to meet the resident's needs..."	F 838	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. 838 I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT	

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F 838	Continued From page 10	F 838	PRACTICE: The Facility Assessment will be reviewed/revised by 4/23/23. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The IDT will be educated by the NHA on requirements of the facility assessments by 4/12/23. The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility will review and update that assessment, as necessary, and at least annually. The facility will also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The NHA/Designee will review the facility assessment weekly X 4 weeks and monthly X 2 months to ensure that the facility assessment has been updated with	

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F 838	Continued From page 11	F 838	any changes as needed. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed. Date of Compliance: 4/23/23	