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 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 from 5/20/24 to 5/23/24. Also reviewed in the course of the survey were complaint intakes WY00003873, WY00003878, WY00003872, WY00003880, WY00003885, WY00003893, and WY00003892. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing FDA: Food and Drug Administration LPN: Licensed Practical Nurse MDS: Minimum Data Sheet Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services;	F 576		6/17/24

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

Electronically Signed | 06/17/2024

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F 576	Continued From page 1 (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure mail was delivered, including on Saturday. The census was 116. The findings were: 1. Interview with 7 residents during a group interview on 5/21/24 at 1:56 PM revealed the facility no longer delivered mail to residents on Saturday. The residents revealed the transportation aide was previously responsible to ensure Saturday mail delivery; however, he told residents that would no longer occur.	F 576	Corrective action: As of June 17, 2024, residents will receive mail delivered by the Post Office on the day of delivery, including Saturday Systemic Changes: On June 13, 2024, staff were educated on resident mail delivery on Saturday, if delivered by the Post Office Monthly X 3 months the NHA or designee	

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F 576	Continued From page 2 2. Interview with the DON on 5/23/24 at 10:27 AM confirmed the transportation aide was responsible for ensuring mail delivery occurred on the weekends. 3. Interview with the transportation aide on 5/23/24 at 10:50 AM confirmed resident mail was no longer delivered on Saturday. He revealed the post office did not deliver to the facility until after he left the facility at 11 AM. Further interview revealed the residents' mail had not been delivered on Saturday for "about 4 months."	F 576	will complete an audit to determine if residents received mail on Saturday if delivered by the Post Office Monitoring: Audits will be reported monthly to QAPI and medical director for recommendations.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		6/17/24

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F 584	Continued From page 3 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative interview, and medical record review, the facility failed to ensure a safe and homelike environment in 1 of 4 units (Pine). The findings were: 1. Multiple random observations during the survey timeframe showed residents from the Cottonwood unit would wander into the Pine unit and the Pine staff would have to assist or redirect the residents. The Pine residents were not observed on the Cottonwood unit. 2. Review of the medical record for resident #98 showed the following concerns: a. Review of a behavior note dated 3/9/24 and timed 9:36 AM showed "resident intruding into Pine [male/female] residents room, removing cue entry/name signs from the door and belongings from inside room. [Male/female	F 584	Corrective action: As of June 17th. 2024, residents on Pine will have a safe and homelike environment. Identification of others: As of June 17, 2024 Nursing units will have a safe, clean, comfortable, and homelike environment. Systemic Changes: On June 13, 2024, staff were educated on safe, clean, comfortable and homelike environment, including allowing wandering residents expend energy, encourage interaction and engagement, redirecting a resident if another resident is upset by entering their room as indicated by	

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F 584	Continued From page 4 resident's [spouse] expressed anger that resident intrudes into [the resident's] room, stating it is an invasion of [the resident's] privacy and [s/he] requested something to be done about it immediately. This nurse and nursing staff increase rounding on resident to keep watch on [his/her] wandering throughout unit." b. Review of CNA documentation dated 3/13/24 and timed 11:14 PM showed "Resident has been going into other residents rooms continuously. Try to redirect [him/her] to [his/her] own room and then goes back into others rooms. Continue to redirect." c. Review of CNA documentation dated 3/14/24 and timed 12:04 AM showed "Resident entered another residents room while I was in the middle of changing the resident and asked [him/her] to leave numerous times before [s/he] finally left." d. Review of a behavior note dated 3/14/24 and timed 7:30 PM showed "Resident pacing and wandering unit throughout the day. [S/he] wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision." e. Review of a behavior note dated 3/27/24 and timed 1:42 AM showed "Resident found in room 1318 (Pine unit) and was eating a snack. [S/he] told resident of that room "I'm gonna eat you" CNA removed resident from room." 3. Interview on 5/20/24 at 3:36 PM with medication aide #1 revealed having the doors	F 584	reasonable care with the disease process and cognitive changes disrupting society norms of normal human interaction. Weekly for 4 weeks then monthly X 2 months the DON or designee will complete an observation and interview audit to determine if the Pine unit is homelike and safe. Monitoring: On a monthly basis, the DON or designee will present the audit findings to the Medical Director and QAPI committee for their recommendations.	

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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F 584	Continued From page 5	F 584		

open between the Cottonwood and Pine units had its "ups and downs" because sometimes residents wandered into rooms and items came up missing. Interventions included submitting grievances and trying to find something else for the wandering resident to do.

4. Review of an alert note, dated 5/12/24, showed resident #28's representative was informed of a resident-to-resident altercation and "Daughter was upset, stating that since the doors have been opened a particular resident has been going over and stealing things from [resident's] room and also stated that she has seen this particular resident stealing food from other people. This nurse did not disclose who the other resident was that was involved in the altercation, but daughter was assuming that it was this particular resident that she had been speaking about. Daughter stated that she would be putting in a grievance for the doors being open."

5. Interview on 5/22/24 at 1:17 PM with resident #5's representative revealed the doors between the Cottonwood and Pine units were opened on 2/27/24. The resident's representative was concerned about the safety of resident #5 and had placed a video camera in his/her room. The resident's representative had documented 18 circumstances in which a resident had wandered into resident #5's room uninvited. Further, water had been spilled on the floor and photographs had been rearranged.

6. Interview on 5/22/24 at 4:09 PM with resident #91's representative revealed the privacy of the residents on the Pine unit had gone "downhill" since the doors between the Cottonwood and Pine units had been opened. The resident's

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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F 584	Continued From page 6	F 584		

representative stated he had witnessed both a female and male resident from the Cottonwood unit enter the room of the resident on separate occasions when the door had been closed. In addition, food and personal property had gone missing. The resident's representative was angry about the situation and stated it did not do any good to complain.

7. Interview with LPN #1 on 5/23/24 at 8:24 AM revealed resident #98 from the Cottonwood unit would wander into resident rooms on the Pine unit which "upsets the [residents] over there". The LPN stated staff would attempt to redirect the resident back to the Cottonwood unit; however, redirecting the resident was difficult at times as s/he often refused. In addition, resident #26 had advanced Alzheimer's disease and would wander throughout both the Pine and Cottonwood units including entering resident's rooms. The LPN stated resident #26 did not have aggressive behaviors and wandered out of curiosity.

8. Interview with CNA #1 on 5/23/24 at 8:35 AM revealed resident #98 was very difficult to care for, exhibited aggressive behaviors, and wandered into other resident's rooms. The CNA stated the resident had recently been staying in the back hallway and she would check on him/her every 2 hours. In addition, the CNA stated the family members of the residents on the Pine unit were very upset about the resident's wandering.

9. Interview with CNA #2 on 5/23/24 at 8:43 AM revealed the opening of the doors between the Cottonwood and Pine units had caused a "massive issue" as the levels of dementia were very different between the two units, and the families of the Pine residents were upset. The

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F 584	Continued From page 7	F 584		

CNA stated since the doors were opened the behaviors of the residents on the Cottonwood unit had caused an increase in the behaviors of the residents on the Pine unit. The CNA stated resident #98 would come into the Pine unit and urinate and defecate on the floor and wander into other resident's rooms causing resident #86 to be fearful and scared to go into his/her room; choosing to sleep in a recliner in the common room. In addition, the CNA stated staffing was a concern as the units used to be staffed with 2 CNAs on both the day and night shift; however, that had been reduced to only 1 CNA on the nightshift with one nurse available for both units. Further, Cottonwood CNAs would not follow their residents into the Pine unit so they became the Pine CNAs responsibility. The CNA added that if staffing was short on another unit in the facility a CNA from Pine would be pulled to fill the vacancy. The CNA also revealed the residents on the Pine unit were not exit seeking; however, the residents on the Cottonwood unit were exit seeking and when they came to the Pine unit, especially during the sundowning hours, the Cottonwood residents would continuously set off the door alarms. The CNA stated concerns from staff and family members went unanswered from the management team.

10. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the doors between the Cottonwood and Pine units were opened because the facility determined having the doors locked was too restrictive for the Cottonwood residents. An evaluation risk was performed before opening the doors and it was determined the level of dementia was the same on both units; however, a reevaluation of the decision had not been completed. In addition, it was the facility's

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F 584	Continued From page 8 expectation the CNAs from Cottonwood would monitor their residents when they wandered into the Pine unit; however, the facility had not increased staffing in either of the secure units and responded to resident representative concerns by informing them the facility was monitoring the situation.	F 584		
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 medical record review, staff interview, policy and procedure review, and review of the state licensing division incident report form, the facility failed to protect the resident's right to be free from abuse by another resident for 3 of 10 residents reviewed for abuse (#26, #63, #106). This failure resulted in harm to resident #106 who experienced sexual abuse. The findings were: 1. Review of the 3/18/24 admission MDS assessment for resident #106 showed s/he was	F 600	Corrective action As of June 17, 2024, resident #26, #63 and #106 will have the right to be free from abuse. Identification of others As of June 17, 2024, residents will have the right to be free from abuse. Systemic Changes	6/17/24

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 600	Continued From page 9 admitted to the facility on 3/14/24 with a diagnosis of Alzheimer's disease. The resident had a BIMS score of 3/15 (severe cognitive impairment), did not exhibit any behaviors, and require supervision or touching for walking up to 50 feet. The following concerns were identified: a. Review of a 5/22/24 alert note showed "CNA notified writer that another resident was found with [his/her] hand up this residents shirt touching [resident's upper chest]. CNA immediately separated residents and notified writer. Writer assessed receiving resident and initiating resident for skin concerns and found nothing to report. Resident accepted being moved away from initiating resident without issue." b. Review of a 5/23/24 "Risk Management Review Note" showed a physical interaction occurred where a resident, [identified as resident #28], had [his/her] hand up a resident's shirt. The residents were immediately separated and monitored for distress. The root cause was determined to be "poor impulse control of other resident [resident #28] and impaired cognition of both residents." c. Interview with the resident's representative on 5/23/24 at 1:49 PM confirmed the resident had been involved in an incident where another resident had placed his/her hands up the resident's shirt. The resident's representative stated it was very upsetting and the resident would have been "horrified" if s/he was cognitively intact. d. Review of a 5/15/24 progress note showed resident #28 had his/her hand down another resident's pants. Interview on 5/23/24 at 3:27 PM with medication aide #1 revealed she had observed resident #28 with his/her hands positioned in the waistband of another resident's	F 600	On June 13, 2024, staff were educated on resident abuse and will have the right to be free from abuse. As of June 17, 2024, The DON or designee will perform Pine observation audit and behavior monitoring audit weekly x 4, monthly x 2 to ensure residents are free from abuse. Monitoring Monthly, the DON or designer will present the audit findings to the Medical director and QAPI committee for their recommendations.	

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F 600	Continued From page 10	F 600		

pants. The medication aide revealed the resident's hand was not far into the waistband and away from the perineal area of the other resident. The medication aide revealed the other resident did not react to the placement of resident #28's hand and neither resident was concerned with the interaction; however, she separated the residents, placed them on increased monitoring, and assisted resident #28 to activities. Further interview revealed resident #28 had not had any previous sexual incidents prior to 5/15/24.

e. Interview with the DON and ADON on 5/23/24 at 2:16 PM revealed the facility had not followed up on the incident which occurred on 5/15/24 and were unable to identify the resident involved at the time of the interview.

2. Review of the 4/23/24 quarterly MDS assessment showed resident #63 was admitted to the facility on 2/27/23. The resident had a BIMS score of 4/15 (severe cognitive impairment), did not exhibit any behaviors, and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, dementia, and anxiety disorder. The following concerns were identified:

a. Review of a 4/21/24 physician communication note showed "Resident involved in a resident to resident with the other resident being the aggressor. Other resident grabbed [resident name] left forearm and attempted to twist it. This caused bruising and broke the skin is (sic) in three areas. Wound was cleansed well and dressed per protocol." The resident causing the injury was identified as resident #62.

b. Review of the "Summary of Investigation" report concluded that physical abuse did occur to resident #63 as inflicted by resident #62. It was determined resident #62 had become

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F 600	Continued From page 11	F 600		

overstimulated during the day which led to the altercation.

c. Interview with the ADON and the DON on 5/23/24 at 3 PM confirmed the injury to resident #63 did occur; however, documentation of the extent of the skin tears and post-event monitoring of the injuries could not be located.

3. Review of a "Summary of Investigation" report showed a resident-to-resident altercation took place on 4/15/24 at 1:40 PM which involved resident #26 and resident #114. Resident #114 pushed resident #26 which resulted in resident #26 falling and hitting his/her head on the floor. Both residents were transported by ambulance to the emergency department. Resident #26 did not require stitches and the CT scan performed was negative. Interventions included one-to-one staff supervision for resident #114 for behaviors and resident safety following return from the hospital. Interview with LPN #1 on 5/23/24 at 8:24 AM revealed resident #114 was very difficult as s/he refused medications and had aggressive behaviors. Resident #114 expired on 4/23/24.

4. Review of the Campbell County Memorial Hospital Long Term Care Abuse Policy, last reviewed on 11/15/23, showed "INTENT: Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. STANDARDS: 1. Providing a safe environment for the resident is one of the most basic and essential duties of our facility...3. This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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(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 600	Continued From page 12 other agencies serving the residents, family members or legal guardians, friends, or other individuals...ABUSE BY OTHER RESIDENTS...If a resident experiences a behavior change resulting in aggression toward other residents, the facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		6/17/24

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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F 609	Continued From page 13 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of the state licensing division incident database, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 1 of 9 samples residents (#62) reviewed for abuse. The findings were: 1. Review of the 3/18/24 annual MDS assessment for resident #62 showed the resident was admitted to the facility on 4/10/23, had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified: a. Review of a 5/15/24 progress note showed resident #28 had his/her hand down another resident's pants. b. Interview with the DON and ADON on 5/23/24 at 2:16 PM revealed the facility had not followed up on the incident which occurred on 5/15/24 and were unable to identify the resident involved at the time of the interview. c. Interview with the DON and ADON on 5/23/24 at 3 PM revealed the resident had been identified as resident #62 and confirmed the allegation of abuse had not been reported to the state licensing division. d. Review of the state licensing division incident database showed no evidence an allegation of sexual abuse which involved resident #62 and resident #28 had been reported. 2. Review of the Campbell County Memorial Hospital Long Term Care abuse policy, last	F 609	Corrective action: As of June 17, 2024, allegations of abuse will be reported to the State Survey Agency are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury Systemic Changes: On June 13, 2024, staff were educated on reporting allegations of abuse to their supervisor to then be reported to the state agency. The DON or designee will audit the allegations of abuse monthly x 3 to ensure reporting to the State Agency was completed. Monitoring: Monthly X 3 months the DON or designee will share the audit to the QAPI Committee and the Medical Director for further guidance.	

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F 609	Continued From page 14 reviewed on 11/15/23, showed "REPORTING ABUSE The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were investigated for 1 of 9 sample residents (#62) reviewed for abuse. The findings were: 1. Review of the 3/18/24 annual MDS	F 610	Corrective action: As of June 17, 2024, for resident #62, any allegations of abuse will be investigated. Resident #62 had MOCA by OT, IDT review of sexual intimacy for consent	6/17/24

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F 610	Continued From page 15 assessment for resident #62 showed the resident was admitted to the facility on 4/10/23, had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified: a. Review of a 5/15/24 progress note showed resident #28 had his/her hand down another resident's pants. b. Interview with the DON and ADON on 5/23/24 at 2:16 PM revealed the facility had not followed up on the incident which occurred on 5/15/24 and were unable to identify the resident involved at the time of the interview. c. Interview with the DON and ADON on 5/23/24 at 3 PM revealed the resident had been identified as resident #62 and confirmed the allegation of abuse had not been investigated or reported to the state licensing division. 2. Review of the Campbell County Memorial Hospital Long Term Care abuse policy, last reviewed on 11/15/23, showed "INVESTIGATION OF ABUSE, NEGLECT, OR MISAPPROPRIATION The facility will conduct an internal investigation. That investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the Sate Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken..."	F 610	assessment, physician review of UARE algorithm, and has capacity to consent to intimate contact with other resident(s). Systemic Changes: As of June 17, 2024, any reported resident allegations of abuse will be investigated by the NHA or designee. On June 13, 2024, staff were educated on investigations of allegations of abuse. The NHA or designee will audit weekly x 4, monthly x2 the allegations of abuse investigations and report the results of that audit. Monitoring: Monthly X 3 months the NHA or designee will share the audit with the QAPI Committee and the Medical Director for further guidance.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge	F 623		6/17/24

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F 623	Continued From page 16 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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F 623	Continued From page 17 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 18 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident representative interview, the facility failed to ensure a discharge notice included care and services for a resident which should not or cannot be provided by the facility for 1 of 1 sample resident (#61) who was issued a 30-day discharge notice. The findings were: 1. Review of a discharge notice issued to resident #61 on 4/23/24 showed "...The transfer or discharge is necessary to meet resident's welfare and the resident's welfare cannot be met in the facility, no return anticipated." Further review showed the facility was pursuing discharge based on the following: a. "On 4/3/2024, the interdisciplinary Team consisting of [staff names] met with family to discuss care decisions that violated [resident name]'s wishes as outlined in [his/her] Medical Durable Power of Attorney (MDPOA). Other	F 623	Corrective action: Resident #61 expired 6/4/24. As of June 17, 2024, the facility will ensure discharge notice includes care and services for a resident which should not or cannot be provided by the facility. Systemic Changes: On June 13, 2024, staff were educated on discharge notices for care and services on a 30-day discharge notice. The DON or designee will audit the discharge notices monthly x 3 and present the findings to the monthly QAPI committee.	

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F 623	Continued From page 19 topics discussed were concerns of [resident #61] receiving inappropriate wound care by [family member #1's name]. During this meeting [family member] showed pictures to the team of skin that she had debrided from [resident #61]'s wounds. [Family member #1] stated she had "scrubbed' the lesions on [resident #61]'s chest with a washcloth. The IDT discussed this action as resulting in harm to the wounds and without medical direction. Further concerns were discussed regarding [resident #61]'s pain. [Resident #61] stated in [his/her] Advanced Directive her MDPOA is to consider the relief of suffering. At the time of this meeting, [Resident family member #2's name] still refused to make decisions to treat [resident #61]'s pain that was ongoing due to his perceptions on pain medicine and alleged past experience. Providers informed [family member #2] he may seek a second opinion and [physician name] provided orders to do so; however, [family member #2] did not follow through with finding a second opinion and [resident #61]'s pain continued left unmanaged until 4/14/24." b. "On 4/17/2024 it was discussed within a family meeting that a family member had made medical orders and provided prescription level wound care supplies to [family member #1] in order to treat [resident #61]. This was done without prior knowledge of wound care team and [facility name] providers." c. "On 4/19/2024 the [outside facility initials] cardiology office called [facility name] regarding [resident #61]'s digoxin [antiarrhythmic]. Family reported to Cardiology that [resident #61] was having an allergy to digoxin. This allegation was not reported to [facility name]. [Facility name] staff and [provider name] had provided education to [family member #2] and [family member #1]	F 623	Monitoring: Monthly X 3 months the DON or designee present the findings to the Medical Director and QAPI committee for their recommendations.	

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F 623	Continued From page 20	F 623		

regarding digoxin and therapeutic labs had been drawn."

d. "On 4/19/2024 Urology communicated with providers that family reported [facility name] was not treating current UTI [urinary tract infection]. [Resident #61] was currently receiving antibiotics."

e. "On 4/23/2024 family scheduled appointments with Urology and Cardiology but failed to notify [facility name] of these appointments in order to schedule transportation. Family expectations of transportation within the same day is not feasible."

f. "Family has been inconsistent in care decisions pertaining to [resident #61]'s PICC line, hospice, care meetings which impact [resident #61]'s care. Specifically saying yes to medical decisions then stating no to any further treatment."

g. "As [resident #61] has had further decline in overall status over the past few weeks, the family have been resistant at times and refused to allow [resident #61] to wear incontinent products, which the IDT recommends to prevent skin breakdown while also a dignity concern for [resident #61]. Family has been resistant at times or refused at times to allow staff to assist [resident #61] in a wheelchair when [resident #61] has been unable to independently ambulate safely."

h. "In the time [resident #61] resided at the [facility name], family have pursued clinical efforts outside [physician name]'s patient management and has attempted to implement their own plan of care without working cohesively with the [facility name] medical team. The MDPOA Advance Directives were not provided to the other physicians and clinics by the family and as the [facility name] provided the MDPOA to the clinics,

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F 623	Continued From page 21	F 623		

the physicians then declined further treatment to follow the MDPOA due to advance dementia and malignancy."

2. Review of a progress note, dated 4/23/24 and timed 11:48 AM, showed "DON contacted [family member #2] via phone call to follow-up on resident's status. Phone call was witnessed by [staff member name], ADON. Discussed medication availability with [family member #2] regarding antibiotics from yesterday and thanked him for picking up the antibiotics that we experienced a delay in getting from our pharmacy. [Family member #2] consented verbally to following Urology recommendations for a maintenance/prophylactic regimen of antibiotic for UTI. [Family member #2] requested a camera in [resident #61]'s room. DON advised that this is obtainable, we have to review a contract to ensure that we are meeting privacy and HIPAA of other residents. [Family member #2] agreed. DON discussed care transition for [resident #61]. Advised that we are not able to meet the needs for [resident #61] at this time and are issuing a 30-day discharge as of today. [Family member #2] will get a certified letter in the mail. Explained that [family member #2] can contest the discharge and file a grievance if desired. [Family member #2] educated to contact the State ombudsman and/or licensing agency for Wyoming and explained contact information will also be in the letter. DON explained [facility name] will support and offer assistance with locating a new facility for [resident #61]. [Family member #2] was not ready to make a decision on where he would like to have referrals sent and will follow-up with facility later. [Family member #2] then declined the request for a camera, stating it would be a waste of money if we are discharging

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F 623	Continued From page 22 [him/her] anyways." 3. Review of a progress note, dated 4/26/24 and timed 4:25 PM, showed "Referral for LTC faxed to [nursing facility name], Casper Wy, [skilled nursing facility name], Casper WY, and [skilled nursing facility name]." 4. Interview with family member #1 on 5/23/24 at 9:47 AM revealed she felt the facility issued the discharge notice in retaliation of her filing a grievance, related to neglect, the day before the notice was issued. 5. Interview with the DON on 5/23/24 at 2:54 PM revealed the resident's family did not feel the providers were providing appropriate care; however, she felt the facility was not meeting the family's requests for care as they were against the resident's wishes. The DON revealed the facility was able to meet the resident's care needs; however, the resident's family requests for care could not be met. Further interview confirmed the care and services provided at the nursing facilities and skilled nursing facilities where referrals had been sent were the same level of care and services the facility was able to provide.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the Resident Assessment	F 641	Corrective action:	6/17/24

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F 641	Continued From page 23 Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 1 of 7 residents reviewed for antibiotics (#26). The findings were: 1. Review of the 2/8/24 annual MDS assessment showed resident #26 was coded as taking an antibiotic with the indication noted box also checked. Review of the resident's physician orders and the 2024 January and February medication administration record showed no evidence the resident had been prescribed an antibiotic. 2. Interview on 5/23/24 at 9:58 AM with the MDS coordinator confirmed the resident had not been prescribed an antibiotic and the MDS assessment was coded incorrectly. 3. According to the MDS 3.0 RAI Manual version 1.18.11 page 483 "N0415F1. Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415F2. Antibiotic: Check if there is an indication noted for all antibiotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)."	F 641	As of June 17, 2024, resident #26 MDS was corrected for accurate reflection of resident status for antibiotics. Identification of others: As of June 17, 2024, resident MDS were audited for accurate reflection of resident status for antibiotics. Systemic Changes: On June 13, 2024, MDS staff were educated by the DON or designee on MDS assessment accuracy for antibiotic orders. The DON or designee will audit monthly for accurate reflection of resident status for antibiotics on the MDS. Monitoring: Audits will be reported monthly to QAPI and medical director for recommendations.	
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	F 656		6/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 656	Continued From page 24 §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 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-	F 656		

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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F 656	Continued From page 25 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive person-centered care plan for 3 of 27 sample residents (#62, #63, #98) reviewed. The findings were: 1. Review of the 3/18/24 annual MDS assessment for resident #62 showed the resident was admitted to the facility on 4/10/23, had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified: a. Review of the resident's care plan, last revised on 4/1/24, showed the resident used an antidepressant medication related to depression and hypersexuality. Review of the current physician orders showed the facility was to monitor target behaviors of tearfulness, sadness, and withdrawal. b. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the resident liked residents of the opposite gender; however, confirmed the care plan did not address what hypersexual behaviors were exhibited by the resident. 2. Review of the 4/23/24 quarterly MDS assessment for resident #63 showed the resident was admitted to the facility on 2/27/23, had a BIMS score of 4 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease, unspecified dementia, and anxiety. Further, the resident was	F 656	Corrective action: As of June 17, 2024; Resident #62 has an individualized care plan and target behaviors for antidepressant prescribed for hypersexual behaviors. Resident #63 has an individualized care plan and target behaviors for antidepressant and antianxiety medications. Resident #98 has an individualized care plan and interventions for behaviors. Identification of others: As of June 17, 2024, resident□s on psychotropics have individualized care plans with target behaviors. Systemic Changes: On June 13, 2024, staff was educated on psychotropic medications and target behaviors. The DON or designee will audit monthly x3 for accurate reflection of target behaviors and care plans for psychotropics. Monitoring:	

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F 656	Continued From page 26 coded as receiving an antianxiety medication. Review of the physician orders showed the resident was prescribed 10 milligrams of buspirone (antianxiety medication) at bedtime for anxiety. The following concerns were identified: a. Review of the resident's care plan, last revised on 4/17/24, showed the resident used an antidepressant medication related to depression. Further review of the care plan showed no evidence a care plan had been developed for the use of the antianxiety medication. b. Interview with the ADON on 5/23/24 at 10:21 AM revealed she thought buspirone was an antidepressant. 3. Review of the 2/9/24 significant change MDS assessment showed resident #98 was admitted to the facility on 10/20/23, discharged to the hospital on 1/8/24, and was readmitted to the facility on 1/16/24 with a new diagnosis of a traumatic brain injury. Additional diagnoses included Alzheimer's disease, unspecified dementia, and depression. A staff assessment showed the resident had severe cognitive impairment and was not administered any high-risk medications. The following concerns were identified: a. Review of the care plan, initiated on 4/18/24, showed the resident had the potential to be physically aggressive related to dementia, poor impulse control, and neurological deficits. The interventions included a directive to "Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document." There was no evidence the facility had completed the analysis and developed a resident-centered comprehensive care plan. b. Interview with the DON and ADON on 5/23/24 at 2:26 PM confirmed the analysis had	F 656	The DON or designee will report monthly to QAPI and medical director for recommendations.	

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F 656	Continued From page 27 not been completed.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of emergency medicine inventory documents, policy and procedure review, and a pharmaceutical reference, the facility failed to ensure residents received medications as ordered by the physician for 1 of 7 sample residents (#61) reviewed for medication administration. The findings were: 1. Review of the 3/19/24 quarterly MDS assessment for resident #61 showed the resident was coded as being severe cognitive impairment and had diagnoses which included cancer, malignant neoplasm of unspecified site of left breast, anemia, malnutrition, Alzheimer's disease, dementia, and mastitis. Review of the care plan, initiated on 4/7/24, showed to monitor and document for signs and symptoms of a urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and a change in eating patterns. The resident will verbalize burning and will have weakness as signs of a UTI. In addition, the care plan showed the resident was on extended antibiotics for	F 658	Corrective action: Resident #61 expired. Identification of others: As of June 17, 2024, residents will receive antibiotics as ordered by the physician. Systemic Changes: On June 13, 2024, staff were educated on obtaining physician ordered antibiotics and notification to the provider and nurse supervisor when not available. The DON or designee will audit monthly x3 that residents received antibiotic as ordered by physician. Monitoring: Audits will be reported monthly to QAPI and medical director for recommendations.	6/17/24

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F 658	Continued From page 28	F 658		

recurrent UTI. The interventions, revised on 5/23/24, included to give antibiotic therapy as ordered. Monitor and document for side effects and effectiveness. The following concerns were identified:

a. Review of the physician orders showed an order for 500 milligrams (mg) of ampicillin was to be administered by mouth four times a day for UTI starting on 4/22/24 at 11:07 AM until 4/23/2024 at 11:59 PM. The order was to finish the 7 days of antibiotics due to the intravenous antibiotic access being removed by the resident on 4/21/24.

b. Review of the April 2024 medication administration record showed the facility failed to administer the medication 4 times between the order date and the time of the next administered dose.

c. Review of a 4/22/24 and timed 4:11 AM progress note showed family requested an oral (and possibly liquid) antibiotic be given to finish the resident's course of antibiotics for treatment of the UTI. The family wanted to discuss, with the provider, setting up maintenance antibiotics to prevent further UTIs. Further review of the progress notes showed on 4/22/24 at 8:24 PM "Orders - Administration Note Text: Ampicillin Oral Capsule 500 MG not available."

d. Review of the 4/24/24 and timed 7:02 AM IDT Risk Management review note showed the date of the incident was 4/22/24 and the type of incident was a delay in care for antibiotic regimen. The root cause was determined to be because the resident was unable to maintain his/her IV and the family requested to change to PO (by mouth) antibiotic to minimize invasive IV starts. An order was placed with the pharmacy and then requested from the backup pharmacy; however, the backup pharmacy did not deliver the

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F 658	Continued From page 29	F 658		

medication. The delay in care was due to availability/supply concerns with the pharmacy. The provider contacted the backup pharmacy and the prescription was filled and picked up by a family member and the night dose was administered. Interventions put into place included the pharmacist at the facility's primary pharmacy was working with the backup pharmacy to establish a process and troubleshoot delivery concerns.

e. Interview with LPN #2 on 5/23/24 at 9:57 AM revealed when the physician placed an order for a medication, the nurses would acknowledge, save, and confirm it before the order was sent to the pharmacy. The LPN stated antibiotics may take a couple of days to arrive; however, the nurses could obtain the medication from the Omnicell (pysix) until the medication arrived.

f. Interview with LPN #1 on 5/23/24 at 10:14 AM revealed when the physician placed an order for a new medication the nurses confirmed the order and would then send the order to the pharmacy. The LPN stated not all medications came right away, especially antibiotics; however, a pyxis was available upstairs that medication could be obtained from until the facility received the medication from the pharmacy.

g. Interview with the DON on 5/23/24 at 10:19 AM revealed the medications were ordered from the primary pharmacy, and the resident would have to wait for them to come the next day if they were ordered after 2 PM. The nursing staff could obtain the medication out of the pyxis, if it was available, and administer it on time. The DON confirmed the resident had missed 4 doses of the antibiotic.

h. Review of the pyxis emergency inventory sheet showed ten 250 mg amoxicillin capsules were available. Review of the progress notes

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F 658	Continued From page 30 failed to show if the nursing staff had asked the physician if amoxicillin could be substituted until the ampicillin arrived. 2. Review of the "Medicine Net.com on 5/31/24 showed "Amoxicillin is a penicillin-type antibiotic. Other members of this class include ampicillin ..." 3. Review of the Medication Administration policy, dated 2/29/24 showed " ...New Medication Starts - Begin new medication orders timely. Begin routine orders on the same day ordered, unless the next dose would be normally given the next day."	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure a safe environment for 2 of 12 residents (#26,#98) reviewed for supervision/accident hazards. The findings were: 1. Review of the 2/8/24 annual MDS assessment for resident #26 showed the resident was admitted to the facility on 12/1/16 and had a diagnosis of Alzheimer's disease. The resident had a BIMS score of 1 out of 15 which indicated	F 689	Corrective action: As of June 17, 2024: Resident# 26 will not have access to zinc oxide creams. Resident #98 will not have access to hand sanitizer. Identification of others:	6/17/24

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F 689	Continued From page 31 severe cognitive impairment. Review of the resident's care plan, initiated on 10/3/23, showed the resident was an "elopement wanderer" related to dementia and staff were to intervene as appropriate. In addition, the care plan stated the resident was at risk for harm from residents due to cognition of self and others on his/her neighborhood and staff were "to be aware of the resident's surrounding to ensure [the resident] is not placing [him/herself] into a dangerous situation. Staff to provide distracting techniques and redirection to encourage this resident away from those situations." The following concerns were identified: a. Multiple observations during the survey timeframe showed the resident wandered between the Pine unit and the Cottonwood unit frequently picking up items and food. b. Review of a "Summary of Investigation" report showed an unwitnessed resident-to-resident altercation took place on 4/15/24 at 1:40 PM which involved resident #26 and resident #114. Resident #114 pushed resident #26 which resulted in resident #26 falling and hitting his/her head on the floor. Both residents were transported by ambulance to the emergency department. c. Review of an "Alert" note, dated 5/22/24 and timed 4:50 PM, showed "Resident was found coming out of a resident's room with Remedy zinc oxide paste skin protectant." The resident had the zinc oxide in his/her mouth, tongue and lips. 2. Review of the 2/9/24 significant change assessment for resident #98 showed the resident was admitted to the facility on 10/23/23 and had diagnoses which included Alzheimer's disease, traumatic brain injury, and depression. The resident had a staff assessment which	F 689	As of June 17th, residents on Pine and Cottonwood will have a safe environment for supervision/accident hazards. Systemic Changes: On June 13, 2024, staff were educated on availability of hazardous items. Weekly x 4 weeks, Monthly X 2 months the DON or designee will complete an audit for a safe environment for supervision and accident and hazards. Monitoring: The DON or designee will present the audit findings to the Medical Director and QAPI committee for recommendations.	

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F 689	Continued From page 32	F 689		

determined the resident to have severe cognitive impairment. Review of the resident's care plan, initiated on 10/20/23, showed the resident was at risk for elopement and wandering related to dementia. The staff were to intervene as appropriate. The following concerns were identified:

a. Review of a 5/12/24 incident report showed resident #98 was involved in an unwitnessed resident-to-resident altercation involving resident #28. Resident #98 resided in the Cottonwood unit and walked over to the Pine unit on 5/12/24 when at 6 PM CNAs heard yelling and responded to find resident #98 with a scratched earlobe. Resident #98 stated s/he had been hit by resident #28. Resident #28 responded with "damn straight I did, [s/he] stole from me." The facility finalized the incident as inconclusive because it was not witnessed.

b. Review of a progress note, dated 5/19/24 and timed 5:06 AM, showed "Resident had a large liquid bowel movement in addition to one episode of emesis. Resident had been going through both kitchens when staff was busy with other residents and eating several different things..."

c. Review of a behavior note dated 5/17/24 and timed 6:09 AM showed the Cottonwood CNA found the resident at approximately 4:30 AM drinking a bottle of hand sanitizer. The amount the resident drank was unknown; however, the bottle was 3/4 full when the CNA found the resident.

d. Review of a behavior note, dated 3/14/24 and timed 7:30 PM, showed "Resident pacing and wandering unit throughout the day. [S/he] wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms

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F 689	Continued From page 33 and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision." 3. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the resident's behaviors were monitored; however, interventions to ensure residents' safety had not been developed. In addition, zinc oxide was stored in resident rooms and used for residents that required incontinence care.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		6/17/24

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F 690	Continued From page 34 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure urinary Foley catheter bags were handled in a manner to prevent urinary tract infections for 1 of 4 (#38) residents with urinary catheters. The findings were: 1. Review of the 3/4/24 significant change MDS assessment for resident #38 showed the resident had a BIMS score of 15 out of 15 (cognitively intact), was coded as having an indwelling catheter, and had diagnoses which included neurogenic bladder and urinary tract infection. The following concerns were identified: a. Observation on 5/20/24 at 2:22 PM of resident care showed CNA #3 lifted the urinary catheter bag above the resident's waist while untangling the tubing. The cloudy urine in the tubing was observed returning toward the resident's bladder. Further observation showed the CNA lifted the urinary bag and held it above the bladder when transferring the resident to a wheelchair via the ceiling lift. b. Interview with the CNA on 5/21/24 at 11:57	F 690	Corrective action: As of June 17, 2024, the facility will ensure for resident #38 the urinary catheter bag will be handled in a manner to prevent urinary tract infections. Identification of others: As of June 17, 2024, the facility will ensure residents with catheter bags will be handled to prevent urinary tract infections. Systemic Changes: On June 13, 2024, staff were educated on how to handle catheter bags to prevent urinary tract infections. The DON or designee will audit urinary catheter bags to prevent urinary tract infections.	

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F 690	Continued From page 35 AM revealed she was educated to keep the urinary catheter bag below the bladder. 2. Interview with the ADON and infection preventionist on 5/22/24 at 10:21 AM revealed it was the facility's expectation of staff to keep the urinary catheter bag below the bladder. 3. Review of the policy and procedure "Urinary Catheter Care" showed "... Maintaining Unobstructed Urine Flow: ...3. The drainage bag must be held/positioned lower than the bladder at all time to prevent the urine in the tubing and drainage bag from flowing back into the bladder."	F 690	Monitoring: The DON or designee will present the audit monthly to QAPI and Medical Director for recommendations.	
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (#98) reviewed for dementia care. This failure resulted in actual harm to resident #98. The findings were: 1. Review of the 2/9/24 significant change MDS assessment for resident #98 showed the resident was admitted to the facility on 10/23/23 and had diagnoses which included Alzheimer's disease, traumatic brain injury, and depression. The	F 744	Corrective action: As of June 17, 2024, resident #98 had a behavior analysis and the resident care plan was updated to reflect resident with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being. Identification of others: As of June 17, 2024, residents with dementia care plans will receive the	6/17/24

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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 744	Continued From page 36 resident had a staff assessment which determined the resident to have severe cognitive impairment. Further review showed the resident had not been prescribed any high-risk medications. Review of the resident's care plan, initiated on 10/20/23, showed the resident was at risk for elopement and wandering related to dementia. The staff were to intervene as appropriate. The following concerns were identified: a. Review of the resident's pain care plan, last revised 5/10/24, showed "Administer pain medications per order, if non-medication interventions are ineffective". The care plan failed to include what the non-medication interventions were. b. Review of the care plan, initiated on 4/18/24, showed the resident had the potential to be physically aggressive related to dementia, poor impulse control, and neurological deficits. The interventions included a directive to "Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document." There was no evidence the facility had completed the analysis and developed a resident-centered comprehensive care plan. c. Review of the care plan for fall prevention, dated 12/26/23, showed "Resident frequently chooses to urinate on the floor, [in his/her] room and also in other residents restroom. Monitory (sic) for wet floors often." d. Review of the neurological care plan, initiated on 1/19/24, showed the resident had an alteration in neurological status related to a head injury. The interventions included cueing, reorientation as needed, reposition or ambulation as tolerated. There was no evidence the facility had developed or implemented interventions to address the resident's neurological deficits.	F 744	appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being. Systemic Changes: On June 13, 2024, staff were educated in resident care plan reflect resident with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being. Weekly x 4 and Monthly X 2 the DON or designee will complete an audit to review care plans to reflect residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being. Monitoring: The DON or designee will present the findings to the monthly QAPI committee and medical director for recommendations.	

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 05/23/2024

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

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F 744	Continued From page 37	F 744		

e. Review of the 2/9/24 significant change MDS assessment showed the resident did not exhibit physical or verbal behaviors towards self or towards others, did not wander, and rejected care 4 to 6 days of the look-back period. The resident was coded as having "improved" behavior since the prior assessment.

f. Review of the 5/21/24 "Regulatory Progress Note" showed the resident was "resistant to participate in review of systems. [S/he] does not allow for assessment and dismisses this provider...[s/he] does have behavioral disturbances of pushing, cursing or name-calling, grabbing, yelling and screaming, kicking and hitting toward staff. [S/he] does not have any behaviors directed at other residents. [S/he] does have an occasion of refusing care as well as self-neglect and throwing or smearing bodily waste...Staff report resident is compliant with medications but generally does not allow for cares or assessment. There are otherwise no additional concerns per staff." Further review of the progress note showed no assessment or behavioral care plan had been developed.

g. Review of the 5/22/24 "Multidisciplinary Care Conference" note showed the resident was incontinent of bowel and bladder; resistive to cares being physical and verbally abuse towards staff. The resident was able to ambulate independently and can be "found walking amongst the neighborhood and checking in on other residents. Currently, there is a barrier with having incontinent episodes and the behaviors that come when [s/he] offered to be cleaned. The most recent provider visit was unsuccessful, as resident denied participation." Further review of the care conference note showed no indication of an assessment to address the resident's behaviors and wandering. The care plan

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 05/23/2024

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

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F 744	Continued From page 38	F 744		

summary showed it had been reviewed with the patient and family; however, it had not been updated.

h. Review of a behavior note, dated 3/9/24 and timed 9:36 AM, showed "resident intruding into Pine [male/female] residents room, removing cue entry/name signs from the door and belongings from inside room. [Male/female] resident's [spouse] expressed anger that resident intrudes into [the resident's] room, stating it is an invasion of [the resident's] privacy and [s/he] requested something to be done about it immediately. This nurse and nursing staff increase rounding on resident to keep watch on [his/her] wandering throughout unit."

i. Review of CNA documentation, dated 3/13/24 and timed 11:14 PM, showed "Resident has been going into other residents rooms continuously. Try to redirect [him/her] to [his/her] own room and then goes back into others rooms. Continue to redirect."

j. Review of CNA documentation, dated 3/14/24 and timed 12:04 AM, showed "Resident entered another residents room while I was in the middle of changing the resident and asked [him/her] to leave numerous times before [s/he] finally left."

k. Review of CNA documentation, dated 3/14/24 and timed 4:01 AM, showed "Resident used call button in bathroom, went in to help [him/her] get out of feces brief and resident started pushing me away while trying to clean [his/her] bottom resident was hitting and punching me and almost fell due to [his/her] behaviors got resident stable in [his/her] step and let [him/her] walk to [his/her] bed."

l. Review of a behavior note, dated 3/14/24 and timed 7:30 PM, showed "Resident pacing and wandering unit throughout the day. [S/he]

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 05/23/2024

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 744	Continued From page 39	F 744		

wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision."

m. Review of a behavior note, dated 3/17/24, showed "Resident has had an incontinent episode of bowel. Took resident to room to be changed. Resident combative with staff, stepping on staff's feet and kicking at them while staff is trying to clean resident. Was not able to get resident cleaned up all the way D/T (due to) the resident kept being combative. Gave resident [his/her] clothes to get dressed and left the room."

n. Review of a 3/18/24 behavior note showed "While trying to shower [resident name] due to have BM (bowel movement) all over [his/her] legs and hands, [resident name] became very combative with CNAs by trying to hit and scratch them. CNA tried talking to [resident name] and explaining what they are doing and the reason for [his/her] shower but were unable to redirect [his/her] behavior during [his/her] shower."

o. Review of an alert note, dated 3/26/24, showed "Resident observed sitting on the floor in hallway; Unable to recall what happened; Was incontinent of BM and had BM all over [him/her] Resident is combative, kicking and hitting at staff the whole time we are trying to assist up and to the shower. Stayed combative the whole time while showering. Noted a small abrasion to right knee, and bruising to right great toe; Unsure if resident hit [his/her] head so neuro's where (sic) were initiated."

p. Review of a behavior note, dated 3/27/24

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 05/23/2024

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 744	Continued From page 40	F 744		

and timed 1:42 AM, showed "Resident found in room 1318 (Pine unit) and was eating a snack. [S/he] told resident of that room "I'm gonna eat you" CNA removed resident from room."

q. Review of an alert note, dated 4/8/24 and timed 5:25 AM, showed "Resident paced the hallways for the entirety of the shift. [Resident] spent long periods of time at the end of the hallway. [Resident] found to have urinated all over the floor. Floors cleaned. [Resident] also spent the shift switching shoes back and forth with another resident ..."

r. Review of a 5/12/24 incident report showed resident #98 was involved in an unwitnessed resident-to-resident altercation involving resident #28. Resident #98 resided in the Cottonwood unit and walked over to the Pine unit on 5/12/24 when at 6 PM CNAs heard yelling and responded to find resident #98 with a scratched earlobe. Resident #98 stated s/he had been hit by resident #28. Resident #28 responded with "damn straight I did, [s/he] stole from me." The facility finalized the incident as inconclusive because it was not witnessed.

s. Review of a behavior note, dated 5/15/24, showed "Resident is at the end of the hall, going to the corner and peeing on the floors. Is trying to take [his/her] brief off and digging feces out of [his/her] brief and throwing it all over the end of the hallway, on the walls, furniture and floor; is not directable, will not follow commands; Assisted x4 assist to the shower and was combative with staff the whole time getting a shower."

t. Review of a behavior note, dated 5/19/24 and timed 6:06 AM, showed at approximately 4:30 AM "the cottonwood CNA found [resident name] drinking a bottle of hand sanitizer." The amount the resident drank was unknown; however, the bottle was 3/4 full when the CNA

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 05/23/2024

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 744	Continued From page 41	F 744		

found the resident.

u. Review of a 5/19/24 behavior note showed "Resident has been changed two times this shift thus far d/t (due to) diarrhea and each time is combative toward staff hitting and kicking at staff. Try to redirect but continues to be combative."

v. Review of a progress note, dated 5/19/24 and timed 5:06 AM, showed "Resident had a large liquid bowel movement in addition to one episode of emesis. Resident had been going through both kitchens when staff were busy with other residents and eating several different things..."

2. Interview with LPN #1 on 5/23/24 at 8:24 AM revealed resident #98 from the Cottonwood unit would wander into resident rooms on the Pine unit which "upsets the [residents] over there". The LPN stated staff would attempt to redirect the resident back to the Cottonwood unit; however, redirecting the resident was difficult at times as s/he often refused.

3. Interview with CNA #1 on 5/23/24 at 8:35 AM revealed the resident was very difficult to care for, exhibited aggressive behaviors, and wandered into other resident's rooms. The CNA stated the resident had recently been staying in the back hallway and she would check on him/her every 2 hours; however, the resident often refused incontinence care.

4. Interview with CNA #2 on 5/23/24 at 8:43 AM revealed the resident would come into the Pine unit and urinate and defecate on the floor and wander into other resident's rooms.

5. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the facility monitored the

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 05/23/2024

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

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F 744	Continued From page 42 resident's behaviors and relied on evaluations and assessments from providers to assist with managing a resident that exhibited behaviors. The DON confirmed a thorough analysis of what triggered the resident's behaviors and interventions and a professional evaluation of the resident had not been completed.	F 744		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, review of policy and procedure, and review of the 2022 FDA Food Code, the facility failed to provide food service in a manner that ensured a safe and appetizing meal for 1 of 1 food service observation of the Pine, Cottonwood and Birch units. The findings were: 1. Observation on 5/22/24 at 11:55 AM showed the steam table food cart was transported from the kitchen to the Pine unit. Dietary aide #1 took the temperature of the food prior to the beginning of meal service at 12:03 PM. The temperature of the turkey casserole was 180 degrees Fahrenheit (F). The following concerns were identified. a. At 12:13 PM the dietary aide washed her hands and began to serve the noon meal. At that	F 804	Corrective action: As of June 17, 2024, the facility will provide food service to provide safe and appetizing meals. Systemic Changes: As of June 17, 2024, nutrition staff will be trained on serving efficiency, utensils, correct food amounts, and serving times to ensure foods are served at proper temperature. The RD or designee will audit weekly x 4 and monthly x 2 for nutrition staff for serving efficiency, utensils, correct food	6/17/24

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 05/23/2024

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 804	Continued From page 43	F 804		

time, she noted she had not arrived with the correct sized serving scoops and had to call the kitchen.

b. At 12:18 PM service was paused when a resident from the Cottonwood unit wandered into the serving area and the dietary aide had to redirect the resident to the common room. The dietary aide then noted she did not have enough food to serve the residents who required a minced and moist meal as well as enough food for the regular diets and had to call the kitchen a second time.

c. At 12:30 PM the nutrition supervisor arrived on the Pine unit and began assisting dietary aide #1. Food service ended at 12:40 PM.

d. Interview with the nutrition supervisor at 12:45 PM revealed the noon meal service should begin at 12 PM on the Pine unit and be completed within 20 minutes; service on the Cottonwood unit should start at 12:30 PM.

2. Observation of the noon meal service on the Cottonwood unit began at 12:47 PM with dietary aide #1 and the nutrition supervisor providing the service. The last plate for Cottonwood unit was served at 1:06 PM and a test plate was requested. The following concerns were identified:

a. At 1:10 PM dietary aide #1 determined the temperature of the turkey noodle casserole was 128 degrees F.

b. The turkey noodle casserole was tasted by the surveyor and found to be lukewarm.

3. Interview with resident #28's representative on 5/21/24 at 9:43 AM revealed the food was constantly served cold.

4. Interview with 7 residents during a group

amounts, and serving times to ensure foods are served at proper temperature.

Monitoring:

The RD or designee will report Audits will monthly to QAPI and medical director for recommendations.

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 05/23/2024

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

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F 804	Continued From page 44	F 804		

interview on 5/21/24 at 1:56 PM revealed residents complained of food being dry, cold or burnt, and with inconsistent portion size during meals. Residents also complained of being served warm drinks with no ice.

5. Interview with the dietitian on 5/23/24 at 11:40 AM confirmed the need for education to dietary aides was necessary to increase speed and to balance efficiency when serving meals. She stated the servers only plated one plate at a time to ensure the food was kept warm, and her expectation was for food to be held at 140 degrees F.

6. Review of the "Food Preparation Practices" policy dated 8/2023, provided by the Infection Control nurse on 5/22/24 showed "...4. All hot food shall be served immediately after preparation. Once prepared, hot food must be held at a temperature of 135 degrees F and above. Highly hazardous foods must never be held at temperatures from 41 degrees F-135 degrees F for longer than 4 hours. "

7. Review of the 2022 FDA Food Code showed "3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:(1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above..."

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 05/23/2024

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 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policy and procedures, and review of the 2022 FDA Food Code, the facility failed to ensure temperatures were monitored for 6 of 6 refrigerator/freezers which stored food for resident use outside of the kitchen (Cottonwood, Pine, Birch, Rehab, Spruce, first floor servery and second floor servery). In addition, the facility failed to ensure a sanitary environment in 1 of 1 food preparation area. The census was 116. The findings were: 1. Observation on 5/23/24 of the refrigerator/freezers outside of the kitchen showed the following concerns: a. The Frigidaire Gallery refrigerator located	F 812	Corrective action: As of June 17, 2024, the facility will monitor temperatures in refrigerators/freezers which store resident food outside the kitchen. As of June 17, 2024, the facility will ensure a sanitary environment in the food preparation area. Systemic Changes: On June 13, 2024, staff educated hand hygiene/safe food handling.	6/17/24

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 05/23/2024

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

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F 812	Continued From page 46 in the Cottonwood unit had milk, cheese, cottage cheese, and juices available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 35 degrees Fahrenheit (F) and the thermometer inside the refrigerator showed a temperature of 42 degrees F. b. The Frigidaire Gallery refrigerator located in the Pine unit had milk, yogurt, juice, and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 35 degrees F and the thermometer inside the refrigerator showed a temperature of 42 degrees F. c. The Delfield refrigerator located in the Cottonwood and Pine servery had thickened liquids, fortified drinks, pop, juice and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 38 degrees F. There was no thermometer inside of the refrigerator. d. The Delfield refrigerator located in the Birch servery had thickened liquids and fortified drinks available for resident use. The thermometer located on the outside of the refrigerator showed a temperature reading of "def" and inside thermometer reading of 38 degrees F. e. The Frigidaire Gallery refrigerator located in the Spruce unit had drinks, fruit, and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 38 degrees F and the thermometer inside the refrigerator showed a temperature of 42 degrees F. f. Interview with the dietitian on 5/23/24 at 11:40 AM revealed monitoring of the refrigerators and freezers on the units was not being done.	F 812	On June 13, 2024, staff educated on temperature logs and monitoring. The RD or designee will audit weekly x 4 and monthly x 2 for hand hygiene and refrigerator / freezer temperature monitoring. Monitoring: The RD or designee will present the Audits monthly to QAPI and medical director for recommendations.	

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 05/23/2024

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 812	Continued From page 47	F 812		

2. Observation on 5/22/24 at 11:20 AM showed cook #1 used gloved hands to place raw hamburger patties on a paper-lined baking sheet. After completing the task, the cook discarded his gloves and without performing hand hygiene donned new gloves and proceeded to pick up seasoning containers. Interview with the dietitian on 5/22/23 at 11:25 AM confirmed the dietary aide should have performed hand hygiene after taking off his gloves. The dietitian educated the dietary aide at that time. In addition, the dietitian revealed she required the kitchen staff to complete the Serve Safe certification within 3 months of hire. In an additional interview with the dietitian on 5/23/24 at 3 PM revealed the cook was to complete his Serve Safe certification by 4/30/24; however, as of 5/23/24 it had not been completed.

3. Review of the "Food Storage/Inventory" policy dated 8/2023, provided by the Infection Control nurse on 5/22/24, showed "...7. All perishable items are stored in either refrigerators maintained at a temperature of 40 degrees F or below or freezers maintained between temperatures of 10 degrees F or below...10. A reliable thermometer is provided for each reach-in or walk-in refrigerator and freezer in an easily readable location. Refrigerator/freezer temperatures are documented daily using approve [sic] temperature logs. Any corrective actions are reported to supervisors immediately."

4. According to the 2022 FDA Food Code "2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that... (I) EMPLOYEES are properly maintaining the temperatures of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during hot and cold holding through daily

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	535022	A. BUILDING _____ B. WING _____	C 05/23/2024

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

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F 812	Continued From page 48 oversight of the EMPLOYEES' routine monitoring of FOOD temperatures..." 5. According to the 2022 FDA Food Code showed "2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		6/17/24

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F 880	Continued From page 49	F 880		

development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(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.

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F 880	Continued From page 50 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, medical record review, staff interview, and policy and procedure review, the facility failed to ensure enhanced barrier precautions were followed for 1 of 4 (#38) resident reviewed for transmission-based precautions. The findings were: 1. Review of the 3/4/24 significant change MDS assessment for resident #38 showed the resident had a BIMS score of 15 out of 15 (cognitively intact), had an indwelling catheter and a urinary tract infection. Review of the resident's care plan, initiated on 5/4/24, showed the resident had precautions in place to prevent the spread of multidrug resistant organisms (MDROs) secondary to the indwelling catheter and wounds. Staff were to use enhanced barrier precautions	F 880	Corrective action: As of June 17, 2024, the facility will ensure enhanced barrier precautions are followed for resident #38 Identification of others: As of June 17th, the facility will ensure enhanced barrier precautions are followed on resident□s that require enhanced barrier precautions per CDC guidance. Systemic Changes: On June 13, 2024, staff were educated on enhanced barrier precautions	

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F 880	Continued From page 51 (EBP) which included the utilization of gowns and gloves for high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (eg, central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care/skin care (eg, any skin opening requiring a dressing). Outside of resident rooms, EBPs to be followed when performing transfers, assisting during bathing in a shared/common shower room, and working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Hand hygiene was recommended before and after resident contact. The following concerns were identified: a. Observation on 5/20/24 at 2:22 PM showed CNA #4 and CNA #3 were only wearing gloves when they placed a brief, shirt, and pants on the resident. The CNAs lifted the urinary catheter up above resident while untangling the urinary tubing. The cloudy urine in the tubing was seen returning toward the resident. The CNA lifted the urinary bag up and held it over the resident's bladder during a transfer to his/her wheelchair, via the ceiling lift, and hooked it on the lift strap above the resident's bladder. The cloudy urine was observed flowing back towards the bladder. Further, no signage was posted on the door or wall for the EBP required. b. Interview with the ADON and infection preventionist on 5/22/24 at 10:21 AM revealed the EBP list included urinary catheter, wounds, and tracheostomies. The EBP sign was tucked inside the PPE (personal protective equipment) hanging storage unit on the resident's door. All staff were trained last April and May on EBP. The facility's expectation for providing care of a resident with a	F 880	Weekly x 4 weeks, Monthly X 2 months the DON or designee will complete an audit on staff performance on enhanced barrier precautions. Monitoring: The audit will be presented to QAPI and medical director on a monthly bases for recommendations.	

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F 880	Continued From page 52 catheter and /or wound would be for nursing staff to be gowned and gloved. 2. Review of the policy and procedure "Enhanced Barrier Precautions", dated 1/6/23, showed "... 2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precaution do not otherwise apply. A. Gloves and gown are applied prior to performing high-contact resident care activities ...3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ...c. transferring, d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); ... 10. Signs are posted on the door or wall outside the resident room indicating the type of precaution and PPE required".	F 880		