

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535022		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2025	
NAME OF PROVIDER OR SUPPLIER THE LEGACY LIVING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S DOUGLAS HWY GILLETTE, WY 82716			
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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 1/14/25 through 1/17/25. The survey was prompted by complaint intakes WY00004097, WY00004112, WY00004126, WY00004127, WY00004134, WY00004141, WY00004155, WY00004173, WY00004176, and WY00004177. The following common abbreviations are used throughout this document: DON: Director of Nursing ADON: Assistant Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set MA-C: Certified Medication Aide RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.			F 000			
F 600 SS=J	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			F 600			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/11/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, closed-circuit camera review, and policy and procedure review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 sample residents (#6) reviewed for abuse and neglect. This failure resulted in the death of resident #6 who exited the facility without being noticed and was outside in winter weather conditions for 9 hours and 17 minutes. This failure resulted in the determination of immediate jeopardy due to the lack of necessary services to ensure residents' safety. On 1/9/25 there were 19 residents on the Cottonwood and Pine units who were identified as high-risk for wandering/elopement. Corrective measures were implemented prior to the survey and compliance was determined to be met on 1/13/25. The findings were: 1. Review of the significant change MDS assessment dated 12/3/24 showed resident #6 had a brief interview for mental status score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease. Further review showed the resident was dependent on staff for toileting hygiene, personal hygiene, bathing, and required substantial/maximal assistance with oral hygiene, upper and lower body dressing, putting on/taking off footwear, and toilet transfer. Review of the resident's activities of daily living care plan last revised on 1/10/25 showed the resident was able to walk independently. Review of the resident's elopement risk/wandering care plan initiated on 2/3/23 showed the resident had a history of exit	F 600	Past noncompliance: no plan of correction required.		

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F 600	Continued From page 2 seeking and wandering behaviors and interventions included "Resident has had successful elopements from the courtyard and [s/he] needs close supervision when [s/he] is outside...Monitor location per nursing "head count" procedure. Document wandering behavior and attempted diversional interventions in behavioral log...The resident's triggers for exit seeking are restlessness and delusional thoughts [s/he] has to go somewhere..." The following concerns were identified: a. Review of an "Abuse or Neglect Investigation" dated 1/10/25 showed staff on the Cottonwood unit were unable to locate resident #6 at approximately 4 AM. A search for the resident was initiated and the resident was located lying on the ground outside in the courtyard, without signs of life. The investigation indicated the closed-circuit television cameras showed the resident exit a door to the courtyard at 7:10 PM on 1/9/25, 9 hours and 15 minutes prior to being found. The facility immediately suspended RN #1, CNA #1, and CNA #2 pending investigation. b. Review of a closed circuit-camera video dated 1/9/25 and beginning at 6:59 PM showed 2 residents on the Cottonwood unit were seated inside the door. The video camera was outside, pointed toward the door, and there was snow visible on the grass and sidewalk. At 7:08:13 PM, resident #6 stood up and ambulated toward the door. The resident exited the Cottonwood unit into the courtyard at 7:08:32 PM and proceeded to walk toward the camera, away from the door, until s/he was no longer visible on the camera, at 7:09:09 PM. At that time, the resident was wearing a long-sleeved shirt, blue jeans or slacks, slippers, and s/he was walking with a shuffled gait. Continued review showed the other resident	F 600			

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F 600	Continued From page 3 remained seated in a chair inside the Cottonwood unit. At 7:21:47 PM, 12 minutes after resident #6 exited the Cottonwood unit, a staff member, who was inside the building, walked toward the exit door. The staff member reached toward something on the right-hand side of the door, then walk away without exiting the door or observing the courtyard outside the Cottonwood unit. Review of a second closed-circuit camera video dated 1/9/25 and beginning at 7:06:34 PM, showed a broad view of the courtyard areas of the Pine and Cottonwood units, where snow was visible throughout the courtyards, including on the walkways. On 1/9/25 at 7:09:32, resident #6 was observed entering the camera's view and ambulating toward the facility. The resident continued to ambulate with his/her arms out to the side until the resident falls to the ground, into the snow, at 7:10:51 PM. Resident #6 continued to move around, in what appeared to be efforts to get up, until his/her movement is not discernable at 7:20 PM. The resident continued to lay in the outside courtyard, in the snow, until the end of the video at 9 PM. Review of a closed-circuit camera video of the Cottonwood and Pine courtyards dated 1/9/25 and beginning at 8:59:33 PM showed resident #6 remained lying in the outside courtyard, in the snow, until the end of the video on 1/10/2025 at 12:00:12 AM. Review of a closed-circuit video of the Cottonwood and Pine courtyards dated 1/10/25 and beginning at 12 AM showed resident #6 lying in the outside courtyard, in the snow. On 1/10/25 at 4:25:22 AM, an individual is observed exiting the facility into the courtyard. The individual was holding a flashlight and walked toward where the resident was lying on the ground. At 4:25:34 AM, the individual observed the resident on the ground, turns, and runs back into the facility, then returns to the	F 600			

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F 600	Continued From page 4 resident. Another individual is observed exiting the facility and walking toward the resident at 4:25:47 AM, 9 hours and 17 minutes after resident #6 exited the Cottonwood unit. c. Review of climate-data.org showed the high temperature in the facility's location on 1/9/25 was 36 degrees Fahrenheit and the low temperature was 15 degrees Fahrenheit. Further review showed the high temperature on 1/10/25 was 33 degrees Fahrenheit and the low temperature was 15 degrees Fahrenheit. 2. Interview with CNA #3 on 1/15/25 at 3:20 PM revealed on 1/9/25 she was assigned to work the night shift on the Pine unit. The CNA revealed at approximately 4:30 AM on 1/10/25, CNA #1 came to the Pine unit to tell her they were unable to find resident #6. The CNA revealed around that same time, CNA #2 notified her that the resident had been found outside, deceased. The CNA revealed she was unsure how long the resident had been outside. CNA #3 stated the facility protocol was to go outside, prior to turning off the alarm, and visually check the area anytime an alarm sounded. The CNA further stated resident #6 was an exit seeking person. The CNA revealed on the night of the incident there were 3 CNAs and 1 nurse for the Pine and Cottonwood units. She revealed 1 CNA and the nurse floated between the units to assist with cares. The CNA revealed she did not see resident #6 during the shift. Further interview revealed staff on the Pine and Cottonwood units were expected to perform rounds on each resident every two hours to provide water, verify call light placement, and assist residents to the bathroom. She further revealed resident #6 needed assistance to toilet. 3. Interview with RN #1 on 1/15/25 at 8:19 PM	F 600			

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F 600	Continued From page 5 revealed she was the charge nurse on the Pine and Cottonwood units for the night shift (6 PM to 6 AM) on 1/9/25. She stated CNA #1 reported resident #6 was missing when he was performing 4 AM rounds. At that time the staff initiated a search, checked the rooms in the Cottonwood unit, and were unable to locate the resident. The RN revealed she told the CNA to check outside and she headed to the Pine unit to look for the resident. The RN revealed the CNA notified her resident #6 was outside before she made it to the Pine unit. The RN revealed the door alarms were supposed to go off and the CNA said he only heard an alarm at midnight. The RN revealed the CNA told her he did not go outside at that time because the doors would lock and he would not be able to get back into the facility. The RN stated she observed resident #6 around 11:30 PM or 12 AM when she administered medications to the resident and CNA #1 also reported seeing the resident around that time. 4. Interview with CNA #1 on 1/15/25 at 8:25 PM revealed he was the float CNA on the Pine and Cottonwood units during the night shift on 1/9/25. The CNA revealed he found the resident outside between 4 AM and 4:30 AM. The CNA revealed he thought he observed resident #6 between 8 PM and 10 PM and did not see him/her during the 12 AM rounds as he was assisting on the Pine unit. The CNA revealed the door alarms went off twice during the shift, once between 8 PM and 10 PM and once around 11 PM. The CNA revealed he did not go outside and check for residents when the door alarms went off because there were other residents at the doors when the alarms sounded. 5. Attempts to interview CNA #2 were	F 600			

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F 600	Continued From page 6 unsuccessful on 1/15/25 and 1/17/25. The CNA's phone number indicated there were restrictions preventing the completion of the call. 6. Interview with nurse supervisor #1 on 1/15/24 at 5:25 PM revealed she was notified by CNA #3 that resident #6 was found outside, deceased, at approximately 4 AM. The nurse supervisor arrived at the facility around 4:30 AM or 4:45 AM and the administrator and law enforcement were already on the Cottonwood unit. At that time, she and the other nurse supervisor removed and replaced all staff assigned to the Cottonwood unit. 7. Interview with nurse supervisor #2 on 1/15/25 at 5:50 PM revealed she was the nurse on call the day of the incident involving resident #6. The nurse supervisor revealed she received a call about the incident from a CNA and she went to the building as a result. The nurse supervisor revealed upon arrival, the administrator, law enforcement, and the other nurse supervisor were already on the Cottonwood unit. She revealed at that time, she and the other nurse supervisor removed and replaced all staff assigned to the Cottonwood unit. 8. Interview with the DON and ADON on 1/16/25 at 1:40 PM confirmed the closed-circuit camera video showed resident #6 exit the facility at 7:08 PM, walk through the courtyard, and fall to the ground. The DON revealed the staff member observed on the video at 7:21 PM was CNA #2, and on the video the CNA performed actions that appeared to be silencing the alarm. She revealed when exit door alarms sounded, staff were expected to look outside for residents and confirmed that did not occur on 1/9/25 at 7:21	F 600			

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F 600	Continued From page 7 PM. Further interview verified the video showed the resident remained on the ground, in the same location until s/he was found by CNA #1 at 4:25 AM, 9 hours and 17 minutes after s/he exited the building. 9. Review of a facility policy titled "Code W (Elopement/Exit Seeking) Wandering Resident or Patient" last revised on 08/2022 showed "...1. Mitigation: Activities and interventions will be planned to reduce or eliminate wandering or escape risks to patients or residents. Every effort will be made to eliminate the risk of wandering residents or patients. Including: locked units, wander guard, staff rounding, door alarms, and/or one to one observation if a patient has altered mental status and requires close observation..." 10. Based on the facility's failure to provide services that were necessary to prevent resident harm, it was determined there was an immediate jeopardy situation on 1/9/25 at 7:08 PM when resident #6 exited the Cottonwood unit without implementation of staff interventions. 11. Review of an "Abatement Plan" dated 1/10/25 showed the following interventions were implemented as a result of the incident: a. All staff on shift at the time of the incident were removed and replaced. b. Assessment of residents for high-risk wandering behaviors was initiated on 1/10/25. c. Implementation of visual checks on wandering residents and spot checks for verification of visual checks was implemented on 1/10/25 at 3:57 PM. d. Door alarm function and maintenance audits were implemented immediately on 1/10/25. Maintenance inspected and tested all doors to	F 600			

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F 600	Continued From page 8 ensure functionality. Door alarm audits were initiated on 1/11/25. e. Staff training was conducted to perform visual rounds on residents every two hours, identifying and managing high-risk wandering behaviors, proper response protocols when door alarm sounds, and documentation of reporting requirements for at-risk residents. In addition, resident education/training was performed to notify the nurse if they leave the facility. Staff Training was initiated on 1/13/25 at 4:11 PM and was ongoing prior to next scheduled shift for staff. f. AD HOC (when necessary or needed) Quality Assurance and Performance Improvement (QAPI) meeting was performed to discuss the incident and interventions. g. Ongoing preventive measures included regular reassessment of all residents for wandering risk during care plan reviews, QAPI monitoring and evaluation for effectiveness of interventions monthly, and emergency drills for elopement. h. Facility compliance was determined to be met on 1/13/25 when staff training was performed, per the education sign-in sheet. 12. The implementation of the "Abatement Plan" was verified during the survey and the immediate jeopardy was determined to have been removed on 1/13/25; however, deficient practice remained at scope and severity of "G."	F 600			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684			2/13/25

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F 684	Continued From page 9 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and physician and staff interview, the facility failed to respond to a change of condition for 1 of 4 sample residents (#3) who experienced a change of condition. This failure resulted in actual harm to resident #3 who reported health concerns and passed away. The findings were: 1. Review of the annual MDS assessment dated 10/2/24 showed resident #3 had a brief interview for mental status score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included heart failure, hypertension, peripheral vascular disease, diabetes mellitus, cerebrovascular accident, anxiety disorder, depression, and asthma. Further review showed the resident required supervision or touching assistance with transfer and toileting hygiene. The following concerns were identified: a. Review of a progress note dated 11/28/24 and timed 7:30 AM showed "...Nurse called to room per staff with resident c/o [complaints of] feeling like [s/he] has Pneumonia and wants an ambulance to the hospital. Vital signs WNL [within normal limits]. No distress noted. Lungs clear to auscultation all fields. O2 sats [oxygen saturation] 91% on 3 L [liters] O2 via NC [nasal cannula]. Resident states [s/he] coughed all night and wanted to go to hospital. No cough noted. Duoneb treatment given. Resident has no more complaints and is in bed asleep..." b. Review of a progress note dated 11/28/24	F 684	Plan of Correction (POC) Facility Name: The Legacy Living and Rehabilitation Center Survey Date: 1/17/25 Deficiency Tag(s): F684 - Quality of Care Completion Date: 2/13/25 Deficient Practice Identified: The facility failed to respond to a change in condition for Resident #3, who reported health concerns and subsequently passed away. The facility did not notify the physician, take appropriate action in response to the resident's complaints, or ensure timely medical intervention. 1. Corrective Actions for Affected Residents Staff Review and Accountability: The nurse responsible for the failure to respond was immediately suspended per policy pending investigation.		

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F 684	Continued From page 10 and timed 2:56 PM showed "...Write [sic] in resident's room to evaluate for c/o heart attack. Vital signs 129/60, 97, 20, 98.7, 91% on 3 L O2 via NC. Resident states that [s/he] has been having chest pain since last night but is unable to rate pain. [S/he] says that [s/he] did not sleep well last night and just wants to lay back in [his/her] bed. Resident assisted to bathroom and back to bed. Denies any chest pain at this time..." c. Review of a progress note dated 11/29/24 and timed 5:50 AM showed the resident was found unresponsive and cardiopulmonary resuscitation, which included chest compressions, was implemented. EMS arrived and pronounced the resident deceased at 5:02 AM. d. Interview with housekeeper #1 on 1/15/24 at 2:52 PM revealed on 11/28/24 around 2:30 PM she entered the resident's room and the resident told the housekeeper s/he had a "F-ing heart attack last night and the nurse didn't give a shit." The housekeeper reported the concerns to the CNAs on the floor and they said they had reported it to the nurse; however, she had not done anything. The housekeeper revealed when she returned to the resident's room, she said a prayer with the resident and then the resident fell asleep. Further interview revealed the housekeeper also reported the resident's concerns to her supervisor and her supervisor reported it to the building charge nurse. e. Interview with MA-C #1 on 1/15/25 at 3:30 PM revealed she worked with the resident on 11/28/24, the day before s/he passed away. The MA-C revealed the resident reported not feeling well and s/he just wanted to sleep. The MA-C revealed she reported the resident's condition to LPN #3; however, she was unsure what the LPN had done.	F 684	A full internal investigation was completed. The nurse was terminated without return to duty following internal investigation. The incident was promptly reported to the Office of Health Licensing and Survey, Adult Protective Services (APS), and law enforcement. 2. Identification of Other Residents at Risk and Corrective Actions Quality Review of Resident Charts: A quality review of resident charts was conducted by a registered nurse to assess responses to changes in condition and identify any trends requiring intervention completed by 1/20/25. Implementation of eINTERACT Change in Condition Evaluations: The facility will begin using the eINTERACT Change in Condition evaluation in its Electronic Health Record (EHR) to ensure timely recognition and appropriate response to resident condition changes. Training will be conducted by the Director of Nursing (DON) at the staff meeting on February 13, 2025. STOP and WATCH Training for CNAs & Medication Aides-Certified: All CNAs and Medication Aides-Certified		

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F 684	Continued From page 11 f. Interview with CNA #4 on 1/15/25 at 3:33 PM revealed she had received report on 11/28/24 that resident #3 was not feeling well. The CNA stated at 6:30 AM the resident felt s/he needed to go to the hospital and s/he thought s/he had pneumonia. The CNA reported the concerns to the nurse; however, the resident remained at the facility. The CNA revealed the resident continued to have concerns throughout the day which included needing assistance with transfers, incontinence, and seizure-like shaking during toileting, which were not normal for the resident. Further interview revealed LPN #3 did not respond to the resident's concerns and stated "oh well [his/her] vitals are fine." g. Interview with RN #3 on 1/15/25 at 4:26 PM revealed she was the building charge nurse on 11/28/24. The RN revealed she was notified by environmental services about concerns made by the resident. The RN revealed she called down and talked to LPN #3 who reported the resident's vital signs were normal; however, RN #3 asked her to check on the resident. The RN revealed when she contacted LPN #3 later to follow-up on the concerns, LPN #3 told her the resident said s/he didn't have any chest pain. h. Interview with CNA #5 on 1/15/25 at 4:30 PM revealed on 11/28/24 the resident was having a difficult time getting out of bed and needed to use the mechanical lift. The CNA stated the resident was not his/her normal self and she reported the concerns to LPN #3 multiple times. The CNA revealed she felt like she was ignored by the nurse and the resident passed away the following day. i. Interview with the resident's physician and nurse practitioner #1 on 1/16/25 at 8:02 AM confirmed they were not notified of any concerns or change in condition for the resident on	F 684	(MA-Cs) will be trained to use the STOP and WATCH function in the EHR to enhance early detection and reporting of resident condition changes. Training will be conducted by the Director of Nursing (DON) at the staff meeting on 2/13/25. 3. Systemic Changes & Preventative Measures Policy Enhancement: The facility will mandate the use of eINTERACT Change in Condition evaluations and STOP and WATCH alerts to ensure proper documentation and escalation of resident concerns and change in condition. Staff Education: Emergency Room Requests: All nursing staff will be trained that if a resident requests to go to the emergency room, the request must be honored, and the provider must be notified. Training will be conducted by the Director of Nursing (DON) at the staff meeting on 2/13/25. Chest Pain & Respiratory Distress Training: Staff was educated via email and 1:1 on 12/2/24 regarding chest pain and respiratory distress, including when to appropriately contact providers. Resident Rounding Education: Additional training was provided via email and 1:1 on		

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F 684	Continued From page 12 11/28/24. They revealed regardless of complaints, if a resident verbalized a desire to go to the hospital, they would expect the nurse to contact them and then send the resident for evaluation. In addition, the physician indicated with all the reported complaints she would expect the nurse to contact her to notify her of a possible change in condition. 2. Interview with LPN #1 on 1/15/24 at 5:59 PM revealed she took over care of the resident on the night shift (6 PM to 6 AM) on 11/28/24. She revealed when RN #2 had given her report at shift change, she reported the resident had not been feeling well; however, she did not indicate she had contacted the physician. The LPN revealed she interacted with the resident during the shift when she provided scheduled medications and the resident did not report any concerns at that time. The LPN revealed the CNA found the resident unresponsive around 4 AM on 1/29/24 and staff began a lifesaving intervention. 3. Interview with LPN #3 on 1/15/25 at 8:08 PM revealed on 11/28/24 the CNA reported the resident thought s/he had pneumonia and s/he wanted to go to the bathroom around 7 AM. At that time, LPN #3 went to the resident's room and listened to the resident's lungs which were clear. The LPN revealed she offered the resident Mucinex and a breathing treatment and the resident accepted the breathing treatment. The LPN revealed when she returned to the resident's room, the resident was sleeping. The LPN stated the CNA reported the resident had verbalized concerns about having a heart attack, to the housekeeper, around noon. The LPN revealed when she checked the resident, s/he did not report any concerns and told the LPN s/he	F 684	1/10/25 regarding the requirement for staff to round on residents every two hours. All nursing staff will be trained on the expectations for documenting and escalating change-in-condition reports using the eINTERACT tool and STOP and WATCH alerts. Future new hires will receive this training as part of their onboarding process. 4. Monitoring & Quality Assurance Integration The facility has integrated this corrective plan into its Quality Assurance & Performance Improvement (QAPI) Program to ensure sustained compliance. Auditing Process: The Director of Nursing (DON) or designee will audit all Change in Condition evaluations and STOP and WATCH alerts for a period of two weeks starting the week of 2/16/25 to ensure proper response and documentation. Ongoing Audit Schedule: After the initial two weeks, audits will be conducted twice weekly for an additional four weeks. Following that, audits will be performed weekly for three months.		

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F 684	Continued From page 13 wanted to go to bed. The LPN revealed she obtained vital signs which were within normal limits. The LPN confirmed she did not notify the resident's physician and she was suspended, then terminated, after the resident passed away. 4. Interview with the DON and ADON on 1/16/25 at 1:40 PM revealed they expected the nurses to notify the provider of all resident changes in condition and resident requests for hospitalization. The DON confirmed LPN #3 did not work after 11/28/24 and she was terminated from the facility as a result of not responding to the resident's change of condition. Further interview confirmed the nurse did provide the resident with an "as needed medication" related to his/her complaints.	F 684	If compliance is sustained, audits will transition to monthly reviews and be incorporated into ongoing QAPI oversight for a period of six months, after which the need for continued monitoring will be re-evaluated. If any concerns arise at any stage, the audit frequency will be increased as needed and additional staff education provided.		
F 689 SS=J	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 medical record review, staff interview, closed-circuit camera review, and policy and procedure review, the facility failed ensure residents received adequate supervision to prevent accidents for 1 of 3 sample residents (#6) reviewed for accident hazards. This failure resulted in the death of resident #6 who exited the facility without being noticed and was outside	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 14 in winter weather conditions for 9 hours and 17 minutes. This failure resulted in the determination of immediate jeopardy due to a lack of implementation of interventions, including adequate resident supervision. On 1/9/25 there were 19 residents on the Cottonwood and Pine units who were identified as high-risk for wandering/elopement. Corrective measures were implemented prior to the survey and compliance was determined to be met on 1/13/25. The findings were: 1. Review of the significant change MDS assessment dated 12/3/24 showed resident #6 had a brief interview for mental status score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease. Further review showed the resident was dependent on staff for toileting hygiene, personal hygiene, bathing, and required substantial/maximal assistance with oral hygiene, upper and lower body dressing, putting on/taking off footwear, and toilet transfer. Review of the resident's activities of daily living care plan last revised on 1/10/25 showed the resident was able to walk independently. Review of the resident's elopement risk/wandering care plan initiated on 2/3/23 showed the resident had a history of exit seeking and wandering behaviors and interventions included "Resident has had successful elopements from the courtyard and [s/he] needs close supervision when [s/he] is outside...Monitor location per nursing "head count" procedure. Document wandering behavior and attempted diversional interventions in behavioral log...The resident's triggers for exit seeking are restlessness and delusional thoughts [s/he] has to go somewhere..." The following concerns were identified:	F 689			

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F 689	Continued From page 15 a. Review of an "Abuse or Neglect Investigation" dated 1/10/25 showed staff on the Cottonwood unit were unable to locate resident #6 at approximately 4 AM. A search for the resident was initiated and the resident was located lying on the ground outside in the courtyard, without signs of life. The investigation indicated the closed-circuit television cameras showed the resident exit a door to the courtyard at 7:10 PM on 1/9/25, 9 hours and 15 minutes prior to being found. The facility immediately suspended RN #1, CNA #1, and CNA #2 pending investigation. b. Review of a closed circuit-camera video dated 1/9/25 and beginning at 6:59 PM showed 2 residents on the Cottonwood unit were seated inside the door. The video camera was outside, pointed toward the door, and there was snow visible on the grass and sidewalk. At 7:08:13 PM, resident #6 stood up and ambulated toward the door. The resident exited the Cottonwood unit into the courtyard at 7:08:32 PM and proceeded to walk toward the camera, away from the door, until s/he was no longer visible on the camera, at 7:09:09 PM. At that time, the resident was wearing a long-sleeved shirt, blue jeans or slacks, slippers, and s/he was walking with a shuffled gait. Continued review showed the other resident remained seated in a chair inside the Cottonwood unit. At 7:21:47 PM, 12 minutes after resident #6 exited the Cottonwood unit, a staff member, who was inside the building, walked toward the exit door. The staff member reached toward something on the right-hand side of the door, then walk away without exiting the door or observing the courtyard outside the Cottonwood unit. Review of a second closed-circuit camera video dated 1/9/25 and beginning at 7:06:34 PM, showed a broad view of the courtyard areas of	F 689			

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F 689	Continued From page 16 the Pine and Cottonwood units, where snow was visible throughout the courtyards, including on the walkways. On 1/9/25 at 7:09:32, resident #6 was observed entering the camera's view and ambulating toward the facility. The resident continued to ambulate with his/her arms out to the side until the resident falls to the ground, into the snow, at 7:10:51 PM. Resident #6 continued to move around, in what appeared to be efforts to get up, until his/her movement is not discernable at 7:20 PM. The resident continued to lay in the outside courtyard, in the snow, until the end of the video at 9 PM. Review of a closed-circuit camera video of the Cottonwood and Pine courtyards dated 1/9/25 and beginning at 8:59:33 PM showed resident #6 remained lying in the outside courtyard, in the snow, until the end of the video on 1/10/2025 at 12:00:12 AM. Review of a closed-circuit video of the Cottonwood and Pine courtyards dated 1/10/25 and beginning at 12 AM showed resident #6 lying in the outside courtyard, in the snow. On 1/10/25 at 4:25:22 AM, an individual is observed exiting the facility into the courtyard. The individual was holding a flashlight and walked toward where the resident was lying on the ground. At 4:25:34 AM, the individual observed the resident on the ground, turns, and runs back into the facility, then returns to the resident. Another individual is observed exiting the facility and walking toward the resident at 4:25:47 AM, 9 hours and 17 minutes after resident #6 exited the Cottonwood unit. c. Review of climate-data.org showed the high temperature in the facility's location on 1/9/25 was 36 degrees Fahrenheit and the low temperature was 15 degrees Fahrenheit. Further review showed the high temperature on 1/10/25 was 33 degrees Fahrenheit and the low temperature was 15 degrees Fahrenheit.	F 689			

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F 689	Continued From page 17 2. Interview with CNA #3 on 1/15/25 at 3:20 PM revealed on 1/9/25 she was assigned to work the night shift on the Pine unit. The CNA revealed at approximately 4:30 AM on 1/10/25, CNA #1 came to the Pine unit to tell her they were unable to find resident #6. The CNA revealed around that same time, CNA #2 notified her that the resident had been found outside, deceased. The CNA revealed she was unsure how long the resident had been outside. CNA #3 stated the facility protocol was to go outside, prior to turning off the alarm, and visually check the area anytime an alarm sounded. The CNA further stated resident #6 was an exit seeking person. The CNA revealed on the night of the incident there were 3 CNAs and 1 nurse for the Pine and Cottonwood units. She revealed 1 CNA and the nurse floated between the units to assist with cares. The CNA revealed she did not see resident #6 during the shift. Further interview revealed staff on the Pine and Cottonwood units were expected to perform rounds on each resident every two hours to provide water, verify call light placement, and assist residents to the bathroom. She further revealed resident #6 needed assistance to toilet. 3. Interview with RN #1 on 1/15/25 at 8:19 PM revealed she was the charge nurse on the Pine and Cottonwood units for the night shift (6 PM to 6 AM) on 1/9/25. She stated CNA #1 reported resident #6 was missing when he was performing 4 AM rounds. At that time the staff initiated a search, checked the rooms in the Cottonwood unit, and were unable to locate the resident. The RN revealed she told the CNA to check outside and she headed to the Pine unit to look for the resident. The RN revealed the CNA notified her resident #6 was outside before she made it to the	F 689			

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F 689	Continued From page 18 Pine unit. The RN revealed the door alarms were supposed to go off and the CNA said he only heard an alarm at midnight. The RN revealed the CNA told her he did not go outside at that time because the doors would lock and he would not be able to get back into the facility. The RN stated she observed resident #6 around 11:30 PM or 12 AM when she administered medications to the resident and CNA #1 also reported seeing the resident around that time. 4. Interview with CNA #1 on 1/15/25 at 8:25 PM revealed he was the float CNA on the Pine and Cottonwood units during the night shift on 1/9/25. The CNA revealed he found the resident outside between 4 AM and 4:30 AM. The CNA revealed he thought he observed resident #6 between 8 PM and 10 PM and did not see him/her during the 12 AM rounds as he was assisting on the Pine unit. The CNA revealed the door alarms went off twice during the shift, once between 8 PM and 10 PM and once around 11 PM. The CNA revealed he did not go outside and check for residents when the door alarms went off because there were other residents at the doors when the alarms sounded. 5. Attempts to interview CNA #2 were unsuccessful on 1/15/25 and 1/17/25. The CNA's phone number indicated there were restrictions preventing the completion of the call. 6. Interview with nurse supervisor #1 on 1/15/24 at 5:25 PM revealed she was notified by CNA #3 that resident #6 was found outside, deceased, at approximately 4 AM. The nurse supervisor arrived at the facility around 4:30 AM or 4:45 AM and the administrator and law enforcement were already on the Cottonwood unit. At that time, she	F 689			

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F 689	Continued From page 19 and the other nurse supervisor removed and replaced all staff assigned to the Cottonwood unit. 7. Interview with nurse supervisor #2 on 1/15/25 at 5:50 PM revealed she was the nurse on call the day of the incident involving resident #6. The nurse supervisor revealed she received a call about the incident from a CNA and she went to the building as a result. The nurse supervisor revealed upon arrival, the administrator, law enforcement, and the other nurse supervisor were already on the Cottonwood unit. She revealed at that time, she and the other nurse supervisor removed and replaced all staff assigned to the Cottonwood unit. 8. Interview with the DON and ADON on 1/16/25 at 1:40 PM confirmed the closed-circuit camera video showed resident #6 exit the facility at 7:08 PM, walk through the courtyard, and fall to the ground. The DON revealed the staff member observed on the video at 7:21 PM was CNA #2, and on the video the CNA performed actions that appeared to be silencing the alarm. She revealed when exit door alarms sounded, staff were expected to look outside for residents and confirmed that did not occur on 1/9/25 at 7:21 PM. Further interview verified the video showed the resident remained on the ground, in the same location until s/he was found by CNA #1 at 4:25 AM, 9 hours and 17 minutes after s/he exited the building. 9. Review of a facility policy titled "Code W (Elopement/Exit Seeking) Wandering Resident or Patient" last revised on 08/2022 showed "...1. Mitigation: Activities and interventions will be planned to reduce or eliminate wandering or	F 689			

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F 689	Continued From page 20 escape risks to patients or residents. Every effort will be made to eliminate the risk of wandering residents or patients. Including: locked units, wander guard, staff rounding, door alarms, and/or one to one observation if a patient has altered mental status and requires close observation..." 10. Based on the facility's failure to provide services that were necessary to prevent resident harm, it was determined there was an immediate jeopardy situation on 1/9/25 at 7:08 PM when resident #6 exited the Cottonwood unit without implementation of staff interventions. 11. Review of an "Abatement Plan" dated 1/10/25 showed the following interventions were implemented as a result of the incident: a. All staff on shift at the time of the incident were removed and replaced. b. Assessment of residents for high-risk wandering behaviors was initiated on 1/10/25. c. Implementation of visual checks on wandering residents and spot checks for verification of visual checks was implemented on 1/10/25 at 3:57 PM. d. Door alarm function and maintenance audits were implemented immediately on 1/10/25. Maintenance inspected and tested all doors to ensure functionality. Door alarm audits were initiated on 1/11/25. e. Staff training was conducted to perform visual rounds on residents every two hours, identifying and managing high-risk wandering behaviors, proper response protocols when door alarm sounds, and documentation of reporting requirements for at-risk residents. In addition, resident education/training was performed to notify the nurse if they leave the facility. Staff Training was initiated on 1/13/25 at 4:11 PM and	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2025
NAME OF PROVIDER OR SUPPLIER THE LEGACY LIVING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 S DOUGLAS HWY GILLETTE, WY 82716		
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F 689	Continued From page 21 was ongoing prior to next scheduled shift for staff. f. AD HOC (when necessary or needed) Quality Assurance and Performance Improvement (QAPI) meeting was performed to discuss the incident and interventions. g. Ongoing preventive measures included regular reassessment of all residents for wandering risk during care plan reviews, QAPI monitoring and evaluation for effectiveness of interventions monthly, and emergency drills for elopement. h. Facility compliance was determined to be met on 1/13/25 when staff training was performed, per the education sign-in sheet. 12. The implementation of the "Abatement Plan" was verified during the survey and the immediate jeopardy was determined to have been removed on 1/13/25; however, deficient practice remained at scope and severity of "G."	F 689			