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	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy Living and Rehabilitation Center	1000 S Douglas Hwy Gillette, WY 82716

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 Based on medical record review, resident representative and staff interview, facility investigation review, and policy and procedure review, the facility failed to ensure a resident's right to be free from physical abuse, verbal abuse, and neglect for 1 of 6 sample residents (#1). The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 6/18/24. 1. Review of a quarterly MDS assessment dated [DATE] showed resident #1 had brief interview for mental status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. The resident had behaviors which included inattention, disorganized thinking, delusions and wandering and s/he was totally dependent on staff for toileting, showering, dressing and personal hygiene. Further review showed the resident had diagnoses which included dementia with other behavioral disturbance, anxiety, transient alteration of awareness, muscle weakness, and need for assistance with personal care. The following concern was identified: a. Review of the facility investigation showed an incident reported on 5/23/24. The investigation showed CNA #2 was observed, via audio/video surveillance, to have several nights without rounding on resident #1 despite claiming she rounded every two hours. The CNA was observed leaving the resident unattended in the bathroom, and the CNA was observed entering the resident's room, at times, without providing resident care. The investigation showed the resident was found attempting to dress and self-propel his/herself out of the bathroom, causing the resident to fall, and showed the resident had gone 13 hours without being checked during the CNA's shift. Further review showed other staff had voiced concerns with the CNA related to the conditions of residents found upon change of shift and what was reported to them, such as saturated briefs and beds, clothing, dentures still in residents' mouths, dried feces, and dried urine left on beds under clean incontinence pads. (continued on next page)

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.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	b. Review of an incident report dated 5/26/27 showed the resident's daughter had provided video footage, with audio, of CNA #1 verbally and physically abusing resident #1. The incident report showed the footage had evidence of the CNA physically pushing the resident in bed and pulling the resident up by one arm, the CNA telling the resident she hated entering the room, and asking the resident what s/he needed. The incident report showed the CNA entered the resident's room several times stating I just took you to the bathroom, you just hit your call light, returning to the room [ROOM NUMBER] minutes later and turning the call light off, slapping his/her hands to his/her hips, and stating you keep turning the call light on. Further review showed the CNA used verbal tone with body language that was aggressive and threatening, and refused to take the resident to the bathroom. The resident made comments following the incident which included you sure I won't get in trouble if I call for help? c. Review of a progress note dated 5/27/24 and timed 10:30 AM showed .COMMUNICATION - with Physician .SBAR Summary: Situation: Resident's (dtr) daughter came into the facility (@) at 945 wanting to speak to the nurse over the unit with some concerns with Saturday and Sunday night shift CNA that worked the unit. Resident's dtr proceeded to show various incidents that were caught on the video camera in the room throughout the night that showed verbal frustration towards resident and an incident that showed potential physical roughness towards the resident when placing resident into the bed. Nurse told dtr that management would be notified promptly to address her concerns. Nurse left resident's room and placed call to the on-call Nursing Management @ 1008 with information received. Assessment (RN)/Appearance (LPN): Resident's skin is clean, dry, and intact with appropriate bruising to R hand from prior day's lab draw from this nurse. ROM is WNL with no s/s of discomfort or injury. Resident's VS WNL for resident. d. Review of a progress note dated 5/27/24 and timed 2:03 PM showed .COMMUNICATION - with Physician .Situation: When laying resident down for rest periods in bed when resident is shown the call light and instructed to call for help resident follows up with statement; Are you sure I can call for help? I won't get in trouble. Assessment (RN)/Appearance (LPN): After resident's incident has had a change in behavior when transferring to bed noted by staff and nurse. Resident appears fearful and making statements as above. The behavior and statements are new to resident. Resident during other cares and periods appears at ease and not in distress with baseline interactions. e. Interview with CNA #1 on 6/19/24 at 11:53 AM revealed she had complained to the administration for months about being overwhelmed and needing help. She stated the resident would call and she didn't know what the resident wanted. The CNA revealed she went to the nurse trying to figure out what the resident wanted. The CNA revealed she had no intention of hurting the resident. She revealed the resident was going to sit on the floor and she had pushed the resident toward the bed to keep him/her from falling. The CNA stated she was crying and frustrated and she had asked for help prior to the shift. f. CNA #2 was not available for an interview. 2. Interview with the resident representative on 6/19/24 at 1 PM revealed the resident felt safe since the doors were closed between the 2 units and she stated staff were treating the resident ok. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of a policy titled Abuse provided by the administrator on 6/18/24 at 1:50 PM showed . Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion . 4. The following plan of correction was implemented by the facility by 6/18/24: a. Corrective actions included resident assessment, CNA suspension during the investigation, facility reported to adult protection agency, state survey agency, and state board of nursing, and disciplinary action for the perpetrators. b. System changes included coaching and education, CNA monitoring, training on rounding requirements and expectations, staff reassignment, and staff education on abuse and neglect b. Identification of others included staff and resident interviews. c. Monitoring included review of CNA audits.