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	04/15/2025

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** 37220 Based on observation, staff interview, medical record review, facility incident investigation review, and performance improvement plan review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 3 of 4 sample residents (#1, #3, #5) involved in a resident-to-resident altercation. This failure resulted in actual harm to resident #1 who suffered a hematoma above his/her left eyebrow and an abrasion under his/her left eye. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 4/8/25. The findings were: 1. Review of the 1/10/25 quarterly MDS assessment showed resident #1 was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain injury, Alzheimer's disease, and non-Alzheimer's dementia. The resident had a BIMS score of 0 out of 15 which indicated severe cognitive impairment and signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. Review of the resident's care plan showed a focus area, revised on 11/4/24, in which s/he was at risk for harm from other residents due to cognition of self and others related to his/her interest in being close to others. Interventions included to direct the resident away from others who may be showing agitation, encourage him/her to participate in activities, be aware of the resident's surroundings to ensure s/he was not placing him/herself in a dangerous situation; observe resident in the common areas to ensure safety; and to redirect to activities or a snack when s/he was in other people's personal space. The following concerns were identified: a. Review of the Legacy Abuse or Neglect Investigation form showed on 3/24/25 at 1 PM resident #4 and resident #6 were observed by EVS technician #1 walking back to their room and resident #1 was following them. Resident #1 was heard stating Don't follow me [resident #1] you bitch. Resident #1 continued to follow resident #4 and resident #6 into their shared suite. EVS technician #1 followed the residents into the suite and witnessed resident #4 put [his/her] hands out forward and push [resident #1] in the chest and shoulder area b. Review of nursing description, dated 3/24/25 and timed 1:50 PM, showed This RN Arrived (sic) to the door entry way into the suite. Resident was found sitting up against the wall with CNA present. Resident was surrounded by two other residents. Abrasion under left eye and small hematoma above left eyebrow .no further injury. Resident denies any pain and then grabbed eye and stated this hurts asked resident about pain again, [s/he] states no. EVS states resident was walking while another resident was holding the door for his/her roommate to come in which s/he stated Do not come this way, you bitch resident proceeded to walk through the entry way when [s/he] was pushed to the floor. (continued on next page)

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

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	04/15/2025

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	c. Interview with EVS technician #1 on 4/15/25 at 12:13 PM revealed he had witnessed resident #4 push resident #1 to the ground; however, because of the angle of the hallway he was unable to see the resident fall to the ground. d. Review of the care plan for resident #4 had a focus area, initiated on 9/20/24, which showed The resident has a mood challenge r/t (related to) mood fluctuations r/t dementia, depression, DM (diabetes mellitus) with fluctuating blood sugars, frequent hallucinations and delusions. History of aggressive behaviors directed at others. Staff were directed to monitor/record/report to MD prn (as needed) risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. 2. Review of the 3/26/25 quarterly MDS assessment for resident #3 showed the resident was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and non-Alzheimer's dementia. The resident had a BIMS score of 4 out of 15 which indicated severe cognitive impairment and had signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. In addition, the resident was coded as wandering 1-to-3 days of the 7-day look-back period. Review of the resident's care plan, initiated on 10/9/24, showed the resident had a behavior challenge related to wandering frequently into other residents' rooms, crying, and exit seeking. Interventions included to encourage the resident to spend time in the common areas to deter him/her from attempting to enter the rooms of other residents and to interfere as necessary to protect the rights and safety of others. 3. Review of the 2/7/25 quarterly MDS assessment for resident #5 showed the resident was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, and depression. The resident had a BIMS score of 3 out of 15 which indicated severe cognitive impairment and had signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. Review of the physician's orders showed the resident was prescribed 10 milligrams of escitalopram (antidepressant) daily for anxiety with target behaviors identified as anxiousness, restlessness, and fixating. The following concerns were identified. a. Review of the Legacy Abuse or Neglect Investigation report showed camera footage of the Cottonwood unit resident hallway revealed resident #3 entered the room of resident #5 on 3/30/25 at 8:06 PM and a staff member entered the room at 8:09 PM. The staff emergency light was activated at 8:10 PM. According to CNA #1 she heard yelling coming from resident #5's room and resident #5 yelling get out. The CNA stated she found both residents on the floor kicking at each other; however, she did not witness contact being made. Review of the nursing assessment, completed following the incident, showed resident #3 had a small skin tear to his/her left outer wrist and resident #5 had a small bruise and a small scratch noted to his/her outer left wrist. Interventions included to make larger name signs for residents' doors which were contrasted with a bright background color. b. Review of a 3/31/25 nursing assessment showed resident #5 was reporting severe left arm pain and showed a decreased range of motion in the left wrist and left elbow, and scattered bruising was noted. The resident was sent for imaging with no acute fracture or dislocation identified. Further review of the facility's investigation showed resident #5 had an unwitnessed fall approximately 30 minutes to an hour after the resident-to-resident incident. The facility determined the injury to resident #5's wrist was most likely from the fall and not the resident-to-resident altercation. (continued on next page)

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	04/15/2025

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	c. Review of resident #5's care plan. revised 3/31/25, showed [the resident] experiences a great amount of anxiety in regard to other (sic) entering [his/her] room without permission. Staff will continue encourage (sic) other wandering residents to not enter [the resident's] room. [The resident] prefers to have [his/her] door open to [his/her] room. But [s/he] is also extremely protective of [his/her] personal items .Staff are to assist with re-directing other residents out of [his/her] room. 4. Interview with the social worker on 4/15/25 at 8:34 AM revealed the facility was transitioning from two secure units to one and there had been a lot of activity which had upset some of the residents and had resulted in an increase in resident-to-resident incidents during March. Further the social worker stated if staff would have been in the resident hallway, heard resident #4 shout at resident #1, and intervened at that time, perhaps the incident could have been avoided. The social worker stated the root cause of many of the incidents was determined to be insufficient supervision throughout the unit and changes had been made to correct the issue as well as education provided to the staff on both dementia and abuse. Further, the facility had moved the social worker's office into the secure unit, and increased supervision and activities. 5. Interview with the NHA and DON on 4/15/25 at 1:30 PM revealed the facility's quality improvement committee had been restructuring the Cottonwood unit which included increased staffing, a full-time activities aide, ensuring staff were located in all locations of the unit, moving the social worker's office into the unit, and ensuring a unit manager was available at all times. In addition, the Cottonwood unit staff were provided an all day dementia care training course through the college and also an in-person 4-hour class on abuse. Further the DON stated the interdisciplinary team performed a daily incident review and written updates and interventions were provided to the unit nurses each day. 6. Review of the staffing schedule from 3/24/25 through 4/14/25 showed the Cottonwood unit was staffed with an additional CNA starting on 3/28/25. In addition, beginning on 4/8/25 the Cottonwood unit had a dedicated licensed nurse. 7. Review of the quality assurance committee's behavior management performance improvement plan (PIP) included a projected schedule with duties and assignments broken down into time blocks for each CNA working on the Cottonwood unit, the dietary aide duties, a dining room seating chart, activities expectations, and risk management duties. The next review of the PIP was scheduled for 4/19/25. 8. Review of the educational documentation provided by the facility showed the Cottonwood unit staff had completed the Dementia Capable Care training on 4/3/25 and the abuse training on 3/19/25. 9. Observation on 4/14/25 starting at 1:59 PM of the Cottonwood unit showed the doors of the residents' rooms had 8 by 10-inch laminated name signs in different bright colors attached to them. Ten residents were observed to be able to ambulate independently with 3 residents observed to wander throughout the unit. Staff were observed providing activities, intervening, and redirecting residents. The CNAs were observed using the charting kiosk in the resident hallway.

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	04/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on observation, staff interview, medical record review, facility incident investigation review, and facility performance improvement plan review, the facility failed to ensure a safe environment for 4 of 6 sample residents (#1, #2, #3, #5) involved in 2 of 3 unwitnessed resident-to-resident altercations reviewed from 3/8/25 to 3/30/25. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 4/8/25. The findings were: 1. Review of the 3/30/25 resident-to-resident altercation involving resident #3 and #5 showed the following: a. Review of the 3/26/25 quarterly MDS assessment for resident #3 showed the resident was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and non-Alzheimer's dementia. The resident had a BIMS score of 4 out of 15 which indicated severe cognitive impairment and had signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. In addition, the resident was coded as wandering 1-to-3 days of the 7-day look-back period. Review of the resident's care plan, initiated on 10/9/24, showed the resident had a behavior challenge related to wandering frequently into other residents' rooms, crying, and exit seeking. Interventions included to encourage the resident to spend time in the common areas to deter him/her from attempting to enter the rooms of other residents and to interfere as necessary to protect the rights and safety of others. b. Review of the 2/7/25 quarterly MDS assessment for resident #5 showed the resident was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, and depression. The resident had a BIMS score of 3 out of 15 which indicated severe cognitive impairment and had signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. Review of the physician's orders showed the resident was prescribed 10 milligrams of escitalopram (antidepressant) daily for anxiety with target behaviors identified as anxiousness, restlessness, and fixating. c. Review of the Legacy Abuse or Neglect Investigation report showed camera footage of the Cottonwood unit resident hallway revealed resident #3 entered the room of resident #5 on 3/30/25 at 8:06 PM and a staff member entered the room at 8:09 PM. The staff emergency light was activated at 8:10 PM. According to CNA #1 she heard yelling coming from resident #5's room and resident #5 yelling get out. The CNA stated she found both residents on the floor kicking at each other; however, she did not witness contact being made. Review of the nursing assessment, completed following the incident, showed resident #3 had a small skin tear to his/her left outer wrist and resident #5 had a small bruise and a small scratch noted to his/her outer left wrist. Interventions included to make larger name signs for residents' doors which were contrasted with a bright background color. (continued on next page)

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	04/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of a 3/31/25 nursing assessment showed resident #5 was reporting severe left arm pain and showed a decreased range of motion in the left wrist and left elbow, and scattered bruising was noted. The resident was sent for imaging with no acute fracture or dislocation identified. Further review of the facility's investigation showed resident #5 had an unwitnessed fall approximately 30 minutes to an hour after the resident-to-resident incident. The facility determined the injury to resident #5's wrist was most likely from the fall and not the resident-to-resident altercation. e. Review of resident #5's care plan. revised 3/31/25, showed [the resident] experiences a great amount of anxiety in regard to other (sic) entering [his/her] room without permission. Staff will continue encourage (sic) other wandering residents to not enter [the resident's] room. [The resident] prefers to have [his/her] door open to [his/her] room. But [s/he] is also extremely protective of [his/her] personal items .Staff are to assist with re-directing other residents out of [his/her] room. 2. Review of the 3/8/25 resident-to-resident incident involving resident #1 and #2 showed the following: a. Review of the 1/10/25 quarterly MDS assessment showed resident #1 was admitted to the facility on [DATE] and had diagnoses which included non-traumatic brain injury, Alzheimer's disease, and non-Alzheimer's dementia. The resident had a BIMS score of 0 out of 15 which indicated severe cognitive impairment and signs and symptoms of delirium including inattention and disorganized thinking which fluctuated. Review of the resident's care plan showed a focus area, revised on 11/4/24, in which s/he was at risk for harm from other residents due to cognition of self and others related to his/her interest in being close to others. Interventions included to direct the resident away from others who may be showing agitation, encourage him/her to participate in activities, be aware of the resident's surroundings to ensure s/he was not placing him/herself in a dangerous situation; observe resident in the common areas to ensure safety; and to redirect to activities or a snack when s/he was in other people's personal space. b. Review of the 3/18/25 quarterly MDS assessment showed resident #2 was admitted to the facility on [DATE] with diagnoses which included non-traumatic brain dysfunction, and non-Alzheimer's dementia. The resident had a BIMS score of 5 out of 10 which indicated severe cognitive impairment; was coded for having hallucinations and delusions; and exhibited verbal and physical behaviors towards others 1-to-3 days of the 7-day look-back period. Review of the resident's care plan showed s/he had a focus area, revised on 12/18/24, of having a behavioral issue which had a potential to be physically aggressive. The care plan identified a trigger for physical aggression being others in close proximity to residents. Interventions included independent time in room, participation in meals/activities in the main areas and removed for downtime, conversation, and television. In addition, if the resident became agitated staff were to intervene before the agitation escalated and guide the resident away from the source of distress. c. Review of a 3/8/25 alert note for resident #2 showed Resident pushed another resident to the floor, when asked why, the resident said resident #1 deserved it and had been annoying [his/her] whole life. The residents were immediately separated and redirected to opposite sides of the dining area. Review of a 3/10/25 risk management note showed Type of incident: Aggression towards another resident. [The resident] initiated physical aggression towards other resident in the main hallway in front of his/her room. Incident was not witnessed. Resident (referring to resident #1) was found on the floor with indication that [resident #2] had pushed [resident #1] out of the way. (continued on next page)

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	04/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of the Legacy Abuse or Neglect Investigation report showed staff did not witness the incident; however, found resident #1 near resident #2's room on his/her knees attempting to get up. The resident showed no signs or symptoms of injury. Resident #2 stated I pushed [him/her] Further review showed due to lack of injury and unwitnessed incident this investigation will conclude unverified. Despite unverified, interventions have been put in place to provide space and time away from each other through structured activities. 3. Interview with the social worker on 4/15/25 at 8:34 AM revealed the facility was transitioning from two secure units to one and there had been a lot of activity which had upset some of the residents and had resulted in an increase in resident-to-resident incidents during March. The social worker stated the root cause of many of the incidents was determined to be insufficient supervision throughout the unit and changes had been made to correct the issue as well as education provided to the staff on both dementia and abuse. Further, the facility had moved the social worker's office into the secure unit, and increased supervision and activities. 4. Interview with the NHA and DON on 4/15/25 at 1:30 PM revealed the facility's quality improvement committee had been restructuring the Cottonwood unit which included increased staffing, a full-time activities aide, ensuring staff were located in all locations of the unit, moving the social worker's office into the unit, and ensuring a unit manager was available at all times. In addition, the Cottonwood unit staff were provided an all day dementia care training course through the college and also an in-person 4-hour class on abuse. Further the DON stated the interdisciplinary team does a daily incident review and written updates and interventions were provided to the unit nurses each day. 5. Review of the staffing schedule from 3/24/25 through 4/14/25 showed the Cottonwood unit was staffed with an additional CNA starting on 3/28/25. In addition, beginning on 4/8/25 the Cottonwood unit had a dedicated licensed nurse. 6. Review of the quality assurance committee's behavior management performance improvement plan (PIP) included a projected schedule with duties and assignments broken down into time blocks for each CNA working on the Cottonwood unit, the dietary aide duties, a dining room seating chart, activities expectations, and risk management duties. The next review of the PIP was scheduled for 4/19/25. 7. Review of the educational documentation provided by the facility showed the Cottonwood unit staff had completed the Dementia Capable Care training on 4/3/25 and the abuse training on 3/19/25. 8. Observation on 4/14/25 starting at 1:59 PM of the Cottonwood unit showed the doors of the residents' rooms had 8 by 10-inch laminated name signs in different bright colors attached to them. Ten residents were observed to be able to ambulate independently with 3 residents observed to wander throughout the unit. Staff were observed providing activities, intervening, and redirecting residents. The CNAs were observed using the charting kiosk in the resident hallway.