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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy Living and Rehabilitation Center	1000 S Douglas Way 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 - Minimal harm or potential for 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. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, facility incident investigation review, and policy and procedure review, the facility failed to protect the residents' right to be free from mental abuse by another resident for 2 of 6 sample residents (#28, #41) reviewed. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #36 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and diagnoses which included non-traumatic brain dysfunction, cerebral palsy, anxiety disorder, depression, and bipolar disorder. The following concerns were identified:a. Review of an incident report dated 5/30/25 showed resident #36 reported resident #9 had touched his/her genitalia, in front of resident #36, before lunch. Resident #36 reported s/he told resident #9 You're nasty, go away and resident #9 left. Further review showed resident #36 reported s/he did not feel safe to the unit manager.b. Interview with resident #36 on 9/11/25 at 8:45 AM revealed about a month ago s/he was doing something in the kitchen area and resident #9 asked resident #36 to play with resident #9's genitals. Resident #36 revealed s/he was mad when the incident happened. Further interview revealed s/he was afraid of resident #9 because resident #9 would playfully grab out toward resident #36 when s/he walked by and resident #36 did not feel it was playful; however, s/he revealed resident #9 had never grabbed resident #36. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #28 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and diagnoses which included medically complex conditions. The following concerns were identified:a. Review of a facility incident report dated 9/10/25 showed resident #28 reported resident #9 entered resident #28's doorway, grasped his/her own genitals which were in his/her pants, and asked resident #28 if s/he wanted to play house. The review showed resident #28 yelled for resident #9 to leave, which s/he did. Further review showed resident #28 reported the incident occurred on 9/6/25.b. Interview with resident #28 on 9/10/25 at 3:42 PM revealed on 9/6/25 s/he was in his/her room, s/he heard someone coming down the hall, and saw resident #9 at resident #28's doorway. The resident revealed resident #9 asked if s/he would play house with him/her. Resident #28 revealed resident #9 had his/her genitals out when resident #9 asked the question. Resident #28 revealed s/he told resident #9 to get the hell out of here. Resident #28 revealed a couple nurses were close and heard the incident and resident #28 felt it was an embarrassing situation. Further interview revealed resident #9 had asked if s/he would touch him/her and play with him/her before in the dining room, resident #9 had done similar things to other residents who were not willing to speak up, and s/he reported it on 9/9/25 during a care conference. S/he did not recall who the nurses were that heard the incident.3. Interview with the facility administrator on 9/11/25 at 11:01 AM revealed the facility was completing staff education, in regard to abuse, following the 9/10/25 incident involving resident #9 and resident #28. She revealed the facility implemented hourly checks on resident #9 and they had developed a performance improvement plan for previous incidents; however, they had not developed a PIP for incidents involving resident #9.4. Review of the facility policy titled Abuse Policy last revised 5/2025 showed .10. Mental abuse is defined as but not limited to humiliation, harassment, threats of punishment, or withholding of treatment or services .Abuse By Other Residents .If a resident experiences a behavior change resulting in aggression toward other residents, the facility conducts further assessment and notifies the primary physician/NP. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization, can then be implemented .