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	03/13/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure transfer and/or discharge notices included the reason for transfer or discharge for 4 of 5 sample residents (#1, #3, #77, #79) reviewed for transfer and discharge. The findings were: 1. Review of a progress note for resident #79 dated [DATE] and timed 2:19 PM showed .This nurse was notified of resident unwitnessed fall. Upon assessment, resident was found to be A&Ox1 [alert and oriented times 1] and slightly decreased LOC [level of consciousness], noted by increased response times. Resident was found to have an abnormal pulse on left wrist and clammy skin. Resident was incontinent at the time of fall, per staff report. Provider on call aware of clinical findings and transfer to ER [emergency room] obtained . The following concerns were identified: a. Review of a Notice of Transfer dated [DATE] showed the resident was provided a notice of transfer to an acute care facility due to his/her needs cannot be met in the facility currently and their welfare is impacted. b. Review of a progress note dated [DATE] and timed 2:20 PM showed spoke with [name], POA regarding resident status. Resident has been out of facility greater than 30 days and is no longer on bed hold for facility. Discussed concerns with previous balance and Medicaid pending status. Resident has not been approved for Medicaid coverage for 2025. Being out over 30 days requires new admission per regulations. Legacy is not currently taking admissions. [POA name] requests to return call to Legacy to further conversation with Medicaid needs. c. Review of a progress note dated [DATE] and timed 2:46 PM showed Spoke with [name], VP care manager at [hospital name] regarding resident discharge from facility. Explained that resident received transfer notice [DATE] with bed-hold notice and appeal rights. Resident remained continuously inpatient beyond 30 days (current 60 days). Bed-hold has expired; resident has lost return rights. Facility is currently closed to admissions; readmission to facility declined at this time as resident is a new admission. d. Review of the medical record showed no evidence the resident was issued a discharge notice following the acute care transfer on [DATE]. e. Interview with the facility administrator on [DATE] at 2:27 PM confirmed the facility did not issue a discharge notice at anytime during the hospital stay. 2. Review of a progress note for resident #77 dated [DATE] and timed 2:21 AM showed Around 0100 [1 AM], resident pushed [his/her] call light and had [his/her] oxygen off. O2 sat [saturation] at 69% and slowly went up to 77%. Resident given a drink and started coughing. O2 sat was 77% pm 2 L, O2 (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	increased to 4L and O2 sat rechecked and was 69% At 0117, received order from [nurse practitioner] to get permission from family to send to ER and she stated if unable to get a hold of family, we could still send to the ER. Call placed to [resident representative] at 0120 [1:20 AM]. [Resident representative] did not answer the phone. Left message that we would be sending resident to the ER if we did not hear otherwise from him. 0124 [1:24 AM], Call placed to 911. 0140 [1:40 AM], ambulance arrived at the facility. Resident's O2 did come up to 93 on 4 L but then went back down to 88 on 2 L. 0153 [1:53 AM], reports given to [name] RN ER nurse. Building charge nurse, [name] notified that resident went to the ER. No call received from resident's [representative] as of this time. The following concerns were identified: a. Review of a Notice of Transfer dated [DATE] showed the resident was provided a notice of transfer to an acute care facility due to his/her needs cannot be met in the facility currently and their welfare is impacted. 3. Review of a progress note for resident #1 dated [DATE] and timed 9:01 PM showed Resident had had several episodes of emesis during the evening med pass, day shift reported to cna's [sic] that the resident had not eaten very much all day. Called to residents [sic] room as he/she had a third episode of emesis. Took resident's vitals: BP 147/74, P124, T100, RR 68, O2 was 77% on 2 and 4 liters of oxygen, resident denies any pain. Assessed resident as I suspected he/she may have aspirated, crackles to right lower lung. Building charge also assessed resident and we agreed resident was in respiratory distress, tachypneic and unable to slow his/her breathing. 9:09 PM Obtained an order from on call provider W.S. to the the [sic] resident to the ER. 21: 12 [9:12 PM] Called 911 to have an ambulance dispatched to the facility. 21:20 [9:20 PM] Notified residents POA, [POA Name], that I was sending his/her [parent] to the ER. [POA] thanked us for notifying him/her, said he/she would contact the co-POA, [co-POA Name], about [their parents] situation and stated, I will probably head to the hospital. 21:31 [9:31 PM] Ambulance service left the facility with the resident. 01:44 [1:44AM] Contacted CCH for an update on the resident, spoke with [Name] R.N. Nurse reported that the resident was awaiting a bed, and that he/she was being admitted for aspiration pneumonia, VS are stable, resident is tachypneic, and has a fever that is 100.4, down from 103.2 Resident was given lactated ringers, resident has a right sided block, and a prolonged QT interval, WBC [white blood cell] count is 20.9. 07:12 [7:12 AM] spoke with [name] R.N. Respiratory panel is negative, CT scan shows Bilateral aspiration. Nurse states that the resident is resting comfortably. The following concerns were identified: a. Review of Notice of Transfer dated [DATE] showed the resident was provided with a notice of transfer to an acute care facility due to his/her needs cannot be met in the facility currently and their welfare is impacted. 4. Review of Notice of Transfer dated [DATE] for resident #3 showed the resident was provided with a notice of transfer to an acute care facility due to his/her needs cannot be met in the facility currently and their welfare is impacted. 5. Interview with the facility administrator on [DATE] at 2:27 PM confirmed the transfer notices provided to the residents or representatives did not include a specific reason for the transfer to acute care.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 8 residents (#37, #63) reviewed for dementia care. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] for resident #63 showed the resident had a BIMS score of 2 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia and anxiety. Review of the resident's care plan, initiated on 1/26/26 revealed the resident had behavioral symptoms which included wandering into other resident's rooms, taking others food and scavenging for food throughout the environment. Interventions were to reorient resident to her/his own food during mealtimes, redirect resident and intervene as appropriate. The following concerns were identified: a. Observation on 3/10/26 at 5:39 PM showed resident #63 took a dish out of the dirty dish bin and licked the plate, which also resulted in food dripping down the front of her/his shirt. There were two CNAs working on the unit who were assisting in a resident room and one dietary aid who was serving food, no other staff was in the area. b. Observation on 3/11/26 at 12:16 PM showed resident #63 took food chunks out of the dirty dish bin and ate them. No staff were in the area at the time of the incident. c. Observation on 3/12/26 at 5:52 PM showed resident #63 removed another resident's plate off of the table and put it in the dirty dish bin. An aid noticed and followed the resident to the bin and directed him/her to put the plate down. The resident followed directions and proceeded to lick his/her fingers clean after putting the dish down. Further observation showed the CNA did not implement interventions to prevent the resident from licking his/her hands or provide hand hygiene. d. Review of a progress note dated 2/25/26 at 3:24 PM showed the IDT team discussed resident #63's involvement in three resident-to-resident altercations during the month. The progress note showed .current care planning, supervision, environmental controls, and/or behavioral interventions may not be sufficient to prevent recurrence. Further review showed the corrective action was to implement more activities, such as catch with the blue ball, folding laundry, dish washing station, resident interaction with similar background, 1 to 1 activities with puzzles, reading, and trivia and the interdisciplinary team would follow up in two weeks and as needed for effectiveness. There was no evidence that the effectiveness was re-evaluated. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #37 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and depression. Review of the resident's care plan, initiated on 1/13/26 showed the resident was an elopement risk and wandered due to impaired safety awareness and dementia. The care plan showed the resident displayed behaviors of wandering into other resident's rooms and exit seeking and had interventions which included identifying a pattern of wandering to adjust to resident's needs and intervene as appropriate, staff was to monitor the resident's location and document wandering behavior, and attempt diversional interventions. The following concerns were identified: a. Review of an Alert Note dated 10/21/25 at 7:25 AM showed on 10/20/25 at 6:26 PM, resident #37 wandered into another resident's room which upset the resident. The other resident responded by swatting at the air, in the direction of resident #37, with no physical contact. At that time, the CNA provided redirection, and de-escalated the situation; however, there was no evidence of evaluation of interventions or behavior triggers. b. Observation on 3/12/26 at 4:35 PM showed resident #37 was at the exit with his/her walker and attempted to open the door and four other residents were in the dining/living area. Further observation showed no staff were present at the time of the incident. 3. Interview with CNA #2 on 3/13/26 at 8:45 AM indicated that staff just know the residents' behavioral patterns and he always made loops around the unit. If there was a resident who needed two or more staff members at once (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were not able to fully watch other residents. 4. Interview with LPN #2 on 3/13/26 at 8:53 AM indicated staff were generally familiar with the residents' behavioral flow, and there was no wander guard in use in the locked unit. She was unaware of specifics of documentation requirements when redirection or intervention was used, aside from putting in an alert chart note that is pushed as a behavior note. She was unaware of any specific rules of minimum staff supervision in common areas. 5.Interview with the NHA on 3/13/26 at 10:13 AM revealed the expectation for resident supervision on the locked unit was to have supervision in common areas at all possible times. She reported if residents left the locked unit with staff, they received continuous 1 to 1 supervision.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a resident, whose hospitalization or therapeutic leave exceeded the bed-hold period under the State plan, was allowed to return to the facility for 1 of 4 sample residents (#79) reviewed for transfer and discharge. The findings were: 1. Review of a progress note for resident #79 dated [DATE] and timed 2:19 PM showed .This nurse was notified of resident unwitnessed fall. Upon assessment, resident was found to be A&Ox1 [alert and oriented times 1] and slightly decreased LOC [level of consciousness], noted by increased response times. Resident was found to have an abnormal pulse on left wrist and clammy skin. Resident was incontinent at the time of fall, per staff report. Provider on call aware of clinical findings and transfer to ER [emergency room] obtained . Review of a Notice of Transfer dated [DATE] showed the resident was provided a notice of transfer to an acute care facility due to his/her needs cannot be met in the facility currently and their welfare is impacted. Further review showed Return to Facility . A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan or facility policy, return to the facility to their previous room if available or immediately upon the first availability of a bed in semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services . The following concerns were identified:a. Review of a progress note dated [DATE] and timed 2:20 PM showed spoke with [name], POA regarding resident status. Resident has been out of facility greater than 30 days and is no longer on bed hold for facility. Discussed concerns with previous balance and Medicaid pending status. Resident has not been approved for Medicaid coverage for 2025. Being out over 30 days requires new admission per regulations. Legacy is not currently taking admissions. [POA name] requests to return call to Legacy to further conversation with Medicaid needs.b. Review of a progress note dated [DATE] and timed 2:46 PM showed Spoke with [name], VP care manager at [hospital name] regarding resident discharge from facility. Explained that resident received transfer notice [DATE] with bed-hold notice and appeal rights. Resident remained continuously inpatient beyond 30 days (current 60 days). Bed-hold has expired; resident has lost return rights. Facility is currently closed to admissions; readmission to facility declined at this time as resident is a new admission.c. Review of the medical record showed no evidence the resident was issued a discharge notice following the acute care transfer on [DATE].d. Interview with the facility administrator on [DATE] at 2:27 PM revealed the resident was not allowed to return because s/he had been gone longer than the bed hold, the facility completed a discharge, they determined the resident would be a readmission, and the facility was not accepting admissions. She confirmed a transfer notice was provided to the resident on [DATE] when the resident required acute care services at a hospital and did not issue a discharge notice at anytime during the hospital stay. Further interview revealed the facility had available beds when the resident was ready to return to the facility. 2. Review of the policy titled Notice of Transfer last revised on 10/21 showed .Return to Facility . A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan or facility policy, return to the facility to their previous room if available or immediately upon the first availability of a bed in semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure pre-admission screening was performed after a new diagnosis of mental illness for 1 of 3 sample residents (#6) with qualifying diagnoses. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #6 had diagnoses which included depression and psychotic disorder (other than schizophrenia). The following concerns were identified:a. Review of the PASARR Level I assessment completed on 3/8/21 showed the resident did not have a psychiatric diagnosis and did not present evidence of mental illness which included a possible disturbance in orientation, affect or mood that was not attributable to dementia or other medical diagnosis.b. Review of the medical record showed the new diagnosis of psychotic disorders with hallucinations due to known physiological condition was created on 9/5/25.c. Interview with the NHA on 3/12/26 at 4:19 PM revealed the resident had a new diagnosis of psychosis that was related to the resident's urinary tract infections that did not trigger the initial PASARR. Further interview confirmed the PASARR II should have been completed.d. Interview with the NHA on 3/12/26 at 5:52 PM confirmed the facility had started a full-scale audit on PASARRs last week.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and activity calendar review, the facility failed to ensure individual activities of preference were provided to 1 of 2 sample residents (#68) reviewed for activities. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #68 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and Review of an Activities-Initial Review dated 6/26/24 showed activities/interests/hobbies the resident participated in included team roping and cribbage. The assessment showed the resident wished to participate in activities while in the home, participate in group activities, participate in outings, participate in 1 to 1 activities with staff, and participate in independent activities. Further review showed activities should be modified to accommodate cognitive deficit and hearing deficit, and assistance should be provided to get the resident to activities. Review of the Activities care plan last revised on 2/16/26 showed the resident enjoyed listening to music while bathing, watching westerns and the news, reading mystery and action books, and playing cribbage. The following concerns were identified:a. Interview with the resident on 3/10/226 at 5:33 PM revealed s/he did not feel s/he was offered choices and s/he wanted to play cards; however, staff would not play with him/her. The resident stated s/he had to wait for family to visit so s/he could play cards. Further interview revealed the resident did not participate in other activities due to his/her decreased mobility. b. Review of the progress notes from 3/5/26 to 3/11/26 showed the resident participated in 1 to 1 activities three times, on 3/5, 3/8, and 3/11. Further review showed no evidence the activities included the resident's preferences, specifically, there was no evidence the facility offered or played cards with the resident.c. Review of the progress notes from 2/10/26 to 3/4/26 showed the resident did not participate in any 1 to 1 activities. d. Review of the progress notes from 1/28/26 to 2/9/26 showed the resident participated in 1 to 1 activities five times, on 1/28, 1/30, 2/1, 2/4, and 2/9. Further review showed no evidence the activities included the resident's preferences, specifically, there was no evidence the facility offered or played cards with the resident.e. Review of the medical record showed no evidence an activity assessment had been completed since 6/24/26.f. Review of the activity calendar for March 2028, February 2028, and January 2028 showed no card game activities were scheduled or provided by the facility.g. Review of the activity participation record from 1/13/26 through 3/12/26 showed no evidence the resident was offered, refused, or participated in any group activities during the time period. Further review showed no evidence the resident was offered, refused, or participated in activities identified as interests on the resident's activity assessment.2. Interview with the activity director on 3/12/26 at 5:36 PM confirmed the facility did not have card games on the activity calendar; however, she revealed there was a group of residents who played cards sometimes. She confirmed resident #68 was not assisted to play to cards with any of the groups. She revealed staff should document refusal of activity participation in the medical record.3. Interview with the activity director on 3/12/26 at 6:20 PM revealed the facility identified 1 to 1 activities were not being completed as they should be and the facility had limited documentation of resident refusals. 4. Interview with the facility administrator on 3/13/26 at 7:49 AM confirmed an activity assessment had not been completed since 6/26/24.5. Review of the policy titled Activity Schedule last revised 5/2025 showed .1. Activities will be designed to meet and support the participants physical, mental, intellectual, and psycho-social well-being. 2. Activities will create opportunities for each resident to have a meaningful life by supporting their domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning) .

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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** Based on staff interview, medical record review, and policy review, the facility failed to ensure adequate supervision was provided to prevent resident injuries for 1 of 8 sample residents (#21) reviewed for accident hazards. The findings were: 1. Review of the MDS assessment dated [DATE] showed resident #21 had a BIMS score of 0 which indicated severe cognitive impairment and had diagnoses of Alzheimer's Disease and Non-Alzheimer's Dementia. Review of resident #21's care plan dated 8/2025 and last revised on 4/28/25 identified that the resident was at risk for falls related to dementia, and poor safety awareness. The following concerns were identified:a. Interview with CNA #1 on 3/13/26 at 10 AM revealed the resident had been sitting at the end of long table in the dining room where his/her chair was pushed up to the table. The resident tried to push the chair out, was unable to get back far enough, the resident climbed over the arm of chair and fell on the floor. The CNA reported she was not close enough to assist.b. Interview with LPN #1 on 3/13/26 at 8:26 AM revealed that the resident was observed trying to step over the arm of the chair that was pushed up to the table, and the resident fell. Further interview revealed the resident could not get his/her leg up high enough to clear the chair.c. Review of a Risk Management Review Note dated 12/18/25 and timed 9:47 AM showed Resident was in the dining room and climbed up on a dining room chair falling. Root Cause: Poor impulse control, poor safety awareness. resident has desire to clean and tidy immediate areas. Treatment required: Transferred to ER for evaluation. Resulting in surgical hip repair with pinning. Interventions put into place: Clear pathways with mobility and exit from dining tables. Ensure that she/he is able to move chair at desire without obstacles behind her. Requires assist with ambulation upon return. Supervision in the dining room during meals.d. Review of a Post Fall Evaluation note dated 1/28/26 and timed 5:45 PM showed on 1/28/26 at 4:32 PM the resident had a witnessed fall in the living room while attempting to ambulate on his/her own with an untied shoelace. Further review showed there was no evidence of injury.e. Review of a Post Fall Evaluation note dated 3/3/26 and timed 5:55 PM showed the resident had an unwitnessed fall in the dining room while s/he attempted to ambulate on her/his own. Further review showed there was no evidence of injury.f. Review of facility policy titled Fall Management last revised 6/2025 showed . 2. Individualized care plan interventions will be implemented for those residents found to be at high risk for falls. Resident and resident representative (if applicable) will be invited to all care plan meetings. Interventions are to be re-evaluated when a resident falls for efficacy. 4. Document the resident's response to interventions and revise interventions if they are not successful.