| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535053 | A. Building<br>B. Wing | 02/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Platte County Legacy Home | 100 19th St<br>Wheatland, WY 82201 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative and staff interview, and facility incident review, the facility failed to ensure adequate supervision was provided to prevent resident injuries for 1 of 4 sample residents (#10) reviewed for accident hazards. The failure resulted in actual harm to resident #10. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #10 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia. The MDS assessment showed the resident had physical and verbal behaviors directed towards others, other behavioral symptoms not directed towards others, and wandering on 1 to 3 days during the look-back period. The following concerns were identified:a. Interview with the resident's representative on 2/18/26 at 10:55 AM revealed the resident had an accident recently where s/he fell down and hit his/her head on a planter. The representative revealed the incident was being looked into and he felt the facility could have used some cameras in the area where the resident fell because there were 2 other residents in the room who had Alzheimer's dementia and it was unclear how the fall occurred. b. Review of a facility incident report dated 2/11/26 and timed 6:08 PM showed staff had completed shift briefing when the nurse heard a crashing sound and rushed to the family room where she observed resident #10 lying on the floor near a plant. Further review of the incident report showed LPN #1 and CNA #1 were assigned to the unit and responded to the incident.c. Review of a progress note dated 2/18/26 and timed 5:54 PM showed Resident arrived at the facility approximately 1300 [1 PM] with [his/her] son [name] and two EMT's. Resident is DNR [do not resuscitate], bed-bound, and under comfort care. Resident has HTN [hypertension], memory loss, osteoporosis. Resident was re-admitted from the hospital in Colorado due to a fall that occurred last week on 02/11/2026 1830 [6:30 PM]. Resident developed a facial fracture (left eye) and had some bruising on [his/her] left hip. Resident is able to move all [his/her] extremities and can turn [him/herself] back and forth. Resident had fentanyl 12 mcg [microgram] patch on [his/her] left neck/ear placed at 0800 [8 AM] from the hospital and needed to be replace every 3 days (72 hours). A foley catheter was present when [s/he] arrived at the facility. Resident will be on thickened liquids (nectar thick). Resident's medication can be crushed or diluted . d. Interview with CNA #1 on 2/20/26 at 8:49 AM revealed she did not see resident #10 fall as staff were assisting resident's out of the dining room. The CNA revealed she had answered a call light and when she returned, she heard resident #10 yelling oh god, oh god. The CNA revealed prior to the incident resident #10 was walking around. e. Interview with LPN #1 on 2/20/26 at 8:53 AM revealed on the day of the incident, residents had just finished dinner and the CNAs were assisting residents out of dining room. The LPN revealed she heard a loud noise and ran to the family room, where resident #10 was found on the floor. She revealed resident #10 could not say what happened and later indicated the injuries occurred during a motor vehicle accident. f. Interview with the social services director on 2/20/26 at 9:27 AM confirmed there were no staff present who observed the incident and revealed there was no actual witnesses to the incident other than the residents, who had cognitive impairment. |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label medications with the date medications were opened and/or expired in 1 of 2 medication storage areas (south medication room). The census was 42. The findings were:1.Observation of the south medication storage room on [DATE] at 8:45 AM showed the general stock for PPD Tubersol vial had been opened, partially used, and no use by date had been written on vial. Further observation showed the general over the counter stock supply of acetaminophen suppositories had expired on 1/2026, and were still available for use.2. Interview with RN #1 on [DATE] at 8:45 am confirmed the Tubersol vial was in use and should have been labeled with a use by date. Further interview confirmed the acetaminophen suppositories were expired and available for use by residents and revealed they should have been discarded.3. Review of facility policy titled Storage of Medication dated [DATE] showed .4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.4. Review of manufacture's package insert, page 10, for Tubersol date last revised [DATE] showed A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure adequate monitoring of psychotropic medications for 2 of 5 sample residents (#2, #10) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #10 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia. The MDS assessment showed the resident had physical and verbal behaviors directed towards others and other behavioral symptoms not directed towards other on 1 to 3 days during the look-back period. Further review showed resident received antipsychotic and antidepressant medications. Review of the current physician orders showed the resident was receiving lorazepam (antianxiety) 0.5 milligrams (mg) by mouth for pain and agitation daily. The following concerns were identified:a. Review of the medical record showed no evidence the facility had identified resident specific or medication specific target symptoms. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a brief interview for mental status score of 4 out 15, which indicated severe cognitive impairment, and had diagnoses which included non-Alzheimer's dementia, Parkinson's disease, anxiety, and depression. Further review showed no behavioral symptoms were present and the resident received antipsychotic and antidepressant medications. Review of the physician orders showed the resident received fluoxetine (antidepressant) 20 mg by mouth daily for depression, olanzapine (antipsychotic) 2.5 mg by mouth in the mourning for anxiety, and olanzapine 5 mg by mouth in the evening for dementia without behavioral disturbance. The following concerns were identified:a. Review of the medical record showed no evidence the facility had identified resident specific or medication specific target symptoms. 3. Interview with the DON on 2/20/26 at 9:36 AM revealed residents who received psychotropic medications should have identified target symptoms identified and staff should monitor the resident for the target symptoms. Interview with the DON on 2/20/26 at 10:31 AM confirmed there were no target symptoms identified for resident #2 and resident #10. 4. Review of the policy titled Assessment of Behavioral/Psychological Symptoms of Dementia provided by the facility on 2/20/26 showed .APA recommends that patients with dementia have a documented comprehensive treatment plan that includes appropriate person-centered nonpharmacological and pharmacological interventions, as indicated . |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on medical record review and staff interview, the facility failed to ensure a bed-hold policy was provided in writing at the time of transfer for 1 of 3 sample residents reviewed (#46) for transfer and discharge. The findings were:1. Review of a progress note dated 12/10/25 and timed 11:03 PM showed resident #46 had small amounts of emesis at beginning of shift and the facility received an order to transport the resident to the emergency department for evaluation and treatment. Review of a progress note dated 12/11/25 and timed 2 AM showed the resident was admitted to the hospital related to a small bowel obstruction, gastrointestinal bleed, sepsis, and supraventricular tachycardia. Review of a Nursing Home Transfer and Discharge Notice dated 12/10/25 showed the resident was provided the transfer notice related to an immediate transfer or discharge required by the residents' urgent medical needs, which cannot be met in the facility. Further review showed the bed-hold policy was marked as attached to the notice; however, no bed-hold policy was attached. Review of the medical record showed no evidence the resident or resident representative was provided a written bed-hold policy at the time of transfer. 2. Interview with the administrator on 2/20/26 at 10:44 AM verified the facility had no evidence the resident received a written bed-hold policy at the time of transfer. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure preadmission screening was performed and was accurate for 1 of 5 sample residents (#3) with qualifying diagnoses. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #3 had diagnoses which included post-traumatic stress disorder. The following concerns were identified:a. Review of a PASRR Level I completed on 7/30/23 showed no primary psychiatric diagnosis listed and the decision indicated a PASRR level II was not indicated due to no evidence of mental illness or intellectual disability. b. Interview with the social services director on 2/20/26 at 9:24 AM revealed the resident's diagnosis of post-traumatic stress disorder was identified after admission and a significant change was not completed. He confirmed a new PASRR should have been completed after the diagnosis was received. |