STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535022	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Wyoming, 82716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/8/25 through 9/1125. Also reviewed in the course of the survey were complaint intakes 1901205, 2599004, 2597746, 2565925, and 2589609. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/25/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, facility incident investigation	F0600	Corrective Action: Resident #28 was assessed on 9/9 and 9/12 for safety and well-being. Resident denied needing any further interventions and did not express changes in baseline level of functioning, isolation, withdrawal or mental anguish. Alleged abuse reported to NHA on 9/9 and State Agency. Investigation was completed 9/15 unverified. Resident declines mental abuse. Resident #41 assessed 6/4/25 and stated feeling safe, not fearful of alleged perpetrator and not fearful to leave her room. Resident declines mental abuse. Hourly rounding implemented for Resident #9, MOCA and sexual capacity assessments. New order to re-attempt urology appointment that Resident has previously refused. Facilitate contact with Resident's wife via a weekly phone call. Provide activities of interest to resident for socialization and engagement. Identification of Others: Additional Resident interviews conducted 9/15/25, 9/19/25 to assess feelings of safety. No complaints or concerns of mental abuse identified.	10/16/2025

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 reverse for further 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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F0600 SS = D	Continued from page 1 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 8/13/25 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 8/21/25 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	F0600	Continued from page 1 Systemic Changes: Facility Abuse Policy updated to ensure compliance with F600 Regulations. All staff received re-education on recognizing and reporting abuse, neglect and misappropriation of property on 9/11/25 with 1:1 verbal education and on 9/24/25 via staff meeting. Social Services to provide education during next Resident Council on 10/16/25 on Types of abuse and reporting abuse. Monitoring: Social Services or designee to conduct an audit interviewing at least two Residents weekly and reviewing grievance logs for concerns about abuse/neglect. Findings will be reported monthly at QAPI and corrective action initiated as needed. Audit will be performed weekly x4 weeks then monthly x3 months.	

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F0600 SS = D	Continued from page 2 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..."	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator	F0609	Corrective Action: Resident #41 assessed 6/4/25 and stated feeling safe, not fearful of alleged perpetrator and not fearful to leave her room. Resident #36 assessed 5/30 and safety plan established. This Resident was assessed again on 9/15/25 and reported she feels safe on her neighborhood and has no other issues/concerns. Unable to identify resident identified on 4/11/25. Interview with all tablemates concluded with no recollection of events. Allegations reported in WDH OHLS incident tracking system. Identification of Others: Resident interviews conducted on 9/15/25 and 9/19/25 to assess for similar concerns,	10/02/2025

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F0609 SS = D	Continued from page 3 of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, State Survey agency incident database review, facility incident review, and policy and procedure review, the facility failed to ensure allegations of abuse and investigation findings were reported for 3 of 6 sample residents (#9, #36, #41) reviewed for abuse allegations. The findings were: 1. Review of a progress note for resident #9 dated 4/12/25 and timed 5:05 PM showed "Note Text: 4/11/2025 09:12 CNA documentation: I was informed by another resident that [resident #9] was being inappropriate at breakfast. Resident told her that [s/he] wanted [him/her] to touch [his/her] [genitals] during breakfast. Informed other resident to alert staff if it occurs again. Receiver calm and required no interventions." 2. Review of a progress note for resident #41 dated 6/4/25 and timed 2:13 PM showed "LATE ENTRY Note Text: Nursing staff communicated to leadership and social services resident stated a [male/female] resident exposed [his/her] genitals to [him/her]. SW [social worker] [name] and SW [name] met with resident who stated a [male/female] resident 'flashed' [him/her]. Resident stated [s/he] had 'heard' from other residents that [s/he] was making advances. SW asked where this occurred, and resident was uncertain. SW asked if it happened in the dining room and resident stated no. SW asked when it occurred, and resident did not recall [s/he] believed 'day time'. SW asked if others were around and may have also been exposed to this and [s/he] stated no, no one was around. Resident stated [s/he] confronted the [male/female] and [s/he] denied doing it. Resident stated multiple times [s/he] feels safe and is not afraid of [him/her] and is not fearful to leave [his/her] room. Following up on this incident	F0609	Continued from page 3 inappropriate comments, unwanted contact, or feelings of safety. No additional allegations identified, resulting in no needs for additional reporting. Observation rounds completed by leadership and nursing staff to monitor resident interactions in dining rooms, hallways, and common areas. No additional concerns identified, resulting in no additional reporting needs. Staff interviews conducted with no additional concerns identified, resulting in no additional needs for reporting. Record review of progress notes, incident logs, and behavior documentation reviewed from 4/1/252-9/15/25 to identify missed patterns or similar behaviors. No further unreported allegations were found. Systemic Changes: Facility Abuse Policy under review to ensure compliance with F600 Regulations. All staff received re-education on recognizing and reporting abuse, neglect and misappropriation of property. Re-education to Leadership at QAPI meeting 10/2/25: requirement to report all allegations immediately, regardless of perceived validity, proper chain of command and notification timelines, documentation expectations. Review of abuse tracking log and Investigation packet. Monitoring: Social Services or designee to conduct an audit reviewing tracking log and comparing to state reporting submissions to ensure compliance. Minimum of two random staff interviews per month to verify knowledge of reporting obligations. Findings will be reported monthly at QAPI and corrective action initiated as needed. Audit will be performed weekly x4 weeks, then monthly x3 months.	

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F0609 SS = D	Continued from page 4 SW interviewed nursing staff who stated this resident was told a negative story about the accused [male/female] resident the day prior. Nursing staff advised the day prior, this resident saw the [male/female] and stated 'are you the [resident] who asks people to play with [his/her] [genitals]?' Nursing staff stated the [male/female] resident did not respond and left the area and expressed to the nursing staff [s/he] was upset at this interaction. Nursing staff advised this resident did not come out for breakfast, only came out for lunch and was not alone with this [male/female] resident at any time. Due to the need for assistance [s/he] is pushed to and from the dining room by staff. Staff confirmed by the time this resident arrived in the dining room multiple other residents were in the dining room. Staff confirmed that today's lunch this resident was sat in the main dining room which is where nutrition staff as well as nursing staff work in order to serve lunch and no resident or staff witnessed any incident. Nursing staff also confirmed that the [male/female] resident who is being accused sits in a separate dining space and would not be in the visual path or vicinity of this resident during the only time in which [s/he] would have left her room. Discussion with administrator following interviews found that the events of the day negate the claim this resident made. No further follow up at this time needed as resident reports [s/he] has no concerns and nursing staff interviews dispute resident claim. It is believed this resident heard claims made by another resident the day prior which impacted [his/her] accusation." 3. 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. 4. Review of the State Survey Agency incident database showed no evidence the incidents involving resident #9, resident #36, or resident #41 were reported. 5. Interview with the facility administrator and DON on 9/11/25 at 1:41 PM confirmed the allegations and investigation findings were not reported to the state survey agency. 6. Review of the facility policy titled "Abuse Policy" last revised on 5/2025 showed "...The facility will ensure that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of	F0609		

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F0609 SS = D	Continued from page 5 resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury and reasonable suspicion of a crime, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures...Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken..."	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, state survey agency incident database review, facility incident review, and policy and procedure review, the facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 6 sample residents (#9, #41) reviewed for abuse. The findings were:	F0610	Corrective Action: Investigation for allegations was completed 9/15/25 resulting in unverified. Resident #41 assessed 6/4/25 and stated feeling safe, not fearful of alleged perpetrator and not fearful to leave her room. Five additional Residents were interviewed between 9/9/25-9/15/25 and reported feeling safe with no concerns. Resident #9 was assessed/interviewed on 9/11 and denied allegations of any inappropriate conduct. Hourly rounding, MOCA sexual capcatiy evaluation, RCA, updates to plan of care for diversional activities and personal hygiene implemented. Identification of Others: Additional Resident interviews conducted 9/15/25, 9/19/25 to assess feelings of safety. Systemic Changes: All allegations will be investigated within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken. Facility Abuse Policy updated to ensure compliance with F600 Regulations. All staff received re-education on recognizing and reporting abuse, neglect and misappropriation of property on 9/11/25 via 1:1 interactions and 9/24/25 via staff meeting. Social Services to provide education during next	10/16/2025

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F0610 SS = D	Continued from page 6 1. Review of a progress note for resident #9 dated 4/12/25 and timed 5:05 PM showed "Note Text: 4/11/2025 09:12 CNA documentation: I was informed by another resident that [resident #9] was being inappropriate at breakfast. Resident told her that [s/he] wanted [him/her] to touch [his/her] [genitals] during breakfast. Informed other resident to alert staff if it occurs again. Receiver calm and required no interventions." 2. Review of a progress note for resident #41 dated 6/4/25 and timed 2:13 PM showed "LATE ENTRY Note Text: Nursing staff communicated to leadership and social services resident stated a [male/female] resident exposed [his/her] genitals to [him/her]. SW [social worker] [name] and SW [name] met with resident who stated a [male/female] resident 'flashed' [him/her]. Resident stated [s/he] had 'heard' from other residents that [s/he] was making advances. SW asked where this occurred, and resident was uncertain. SW asked if it happened in the dining room and resident stated no. SW asked when it occurred, and resident did not recall [s/he] believed 'day time'. SW asked if others were around and may have also been exposed to this and [s/he] stated no, no one was around. Resident stated [s/he] confronted the [male/female] and [s/he] denied doing it. Resident stated multiple times [s/he] feels safe and is not afraid of [him/her] and is not fearful to leave [his/her] room. Following up on this incident SW interviewed nursing staff who stated this resident was told a negative story about the accused [male/female] resident the day prior. Nursing staff advised the day prior, this resident saw the [male/female] and stated 'are you the [resident] who asks people to play with [his/her] [genitals]?' Nursing staff stated the [male/female] resident did not respond and left the area and expressed to the nursing staff [s/he] was upset at this interaction. Nursing staff advised this resident did not come out for breakfast, only came out for lunch and was not alone with this [male/female] resident at any time. Due to the need for assistance [s/he] is pushed to and from the dining room by staff. Staff confirmed by the time this resident arrived in the dining room multiple other residents were in the dining room. Staff confirmed that today's lunch this resident was sat in the main dining room which is where nutrition staff as well as nursing staff work in order to serve lunch and no resident or staff witnessed any incident. Nursing staff also confirmed that the [male/female] resident who is being accused sits in a separate dining space and would not be in the visual path or vicinity of this resident during the only time in which [s/he] would have left her room. Discussion with administrator following interviews	F0610	Continued from page 6 Resident Council on 10/16/25 on Types of abuse and reporting abuse. Re-education to Leadership at QAPI meeting 10/2/25 on: requirement to report all allegations immediately, regardless of perceived validity, proper chain of command and notification timelines, documentation expectations. Review of abuse tracking log and Investigation packet. Monitoring: Social Services or designee to conduct an audit reviewing tracking log and ensuring investigations were completed, with corrective actions identified and documented. Findings will be reported monthly at QAPI and corrective action initiated as needed. Audit will be performed weekly x4 weeks, then monthly x3 months.	

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F0610 SS = D	Continued from page 7 found that the events of the day negate the claim this resident made. No further follow up at this time needed as resident reports [s/he] has no concerns and nursing staff interviews dispute resident claim. It is believed this resident heard claims made by another resident the day prior which impacted [his/her] accusation." 3. Review of the state survey agency incident database showed no evidence the incidents involving resident #9 or resident #41 were reported or investigated. 4. Review of the facility incidents showed no evidence the 4/12/25 or 6/4/25 allegations were investigated. 5. Interview with the facility administrator and DON on 9/11/25 at 1:41 PM confirmed the allegations were not investigated. 6. Review of the facility policy titled "Abuse Policy" last revised on 5/2025 showed "...The facility will conduct an internal investigation. That investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken..."	F0610		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff and resident interview, incident investigation review, and policy and procedure review, the facility failed to ensure residents with dementia received treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 4 sample residents (#9) reviewed for dementia care. The findings were: 1. Review of the annual MDS assessment dated 8/14/25 showed resident #9 had a brief interview for mental	F0744	Corrective Action: Resident #9 will receive the appropriate treatment and services to attain or maintain his highest practical physical, mental, and psychosocial well-being. Hourly rounding implemented for Resident #9, MOCA and sexual capacity assessments. New order to re-attempt urology appointment that Resident has previously refused. Attempt to facilitate contact with Resident's wife via a weekly phone call. RCA performed by IDT 9/29/25 with additional interventions implemented. Care plan updated 9/10/25 and 10/1/25 to reflect individualized approaches. Identification of Others: All Residents with a diagnosis of dementia to be reviewed to ensure care plans reflect individualized dementia care approaches, non-pharmacological interventions are identified and implemented. Systemic Changes: All staff received education on	10/01/2025

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F0744 SS = D	Continued from page 8 status score of 5 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and unspecified dementia with psychotic disturbance. Further review showed the resident had no behavior symptoms present and had a foley catheter in place. Review of the care plan last revised on 9/10/25 showed the resident had "a risk behavior challenge r/t [related to] Specify Behavior: history of making sexually suggestive comments to other residents, often comments are associated with catheter." Interventions included the resident "enjoys cutting paper as a job with scissors," "anticipate and meet the resident's needs: If [resident name] is asking others to 'play with [his/her] [genitals]' [s/he may need catheter care, and "Assist the resident to develop more appropriate methods of coping and interacting and asking for help." The following concerns were identified: a. Review of a progress note dated 11/24/24 and timed 7:08 PM showed "Note Text: This was noted in previous documentation Resident was sitting by the nurse's medication cart, taking [his/her] morning medications. When resident was just about to leave, resident commented, "I am going to go look for someone to play with my [genitals]." Resident was educated that this was not appropriate in this environment. Resident laughed at the education as [s/he] left the cart to go to breakfast. This was noted in previous documentation Later in the morning, a staff member had walked past this resident sitting at the breakfast table and had noted that the resident had [his/her] hand in [his/her] pants and was moving [his/her] hand. Staff member asked resident if [s/he] would remove [his/her] hand from [his/her] pants while [s/he] was in a public setting. Resident was educated on appropriate places to perform private matters. Resident laughed at the education, removed [his/her] hand from [his/her] pants, and verbalized understanding." b. Review of a progress note dated 12/25/24 and timed 8:19 AM showed "...Resident initiated a verbal altercation with another resident after [s/he] accidentally pushed another resident into the table. Yelled at [him/her] to "Shut the hell up." When questioned about the incident, [name] stated that [s/he] and the other resident were going to get the cows in. Attempted to reorient resident..." c. Review of a progress note dated 1/4/25 and timed 8:15 AM showed "Note Text: Activity aide was telling [resident name] what was happening today, after aide was done [resident name] stated [s/he] was looking for someone to play with [his/her] private parts. Aide	F0744	Continued from page 8 dementia care via September staff meeting 9/24/25. Monitoring: DON or designee to conduct an audit reviewing two Residents to ensure: dementia care plans are individualized and current. Minimum two staff interview monthly to confirm training retention and knowledge of dementia care practices. Findings will be reported monthly at QAPI and corrective action initiated as needed. Audit will be performed weekly x4 weeks then monthly x3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535022	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0744 SS = D	Continued from page 9 explain to [resident name] that was not right. [S/He] stated ok and aide went on with her work." d. Review of a progress note dated 3/1/25 and timed 3:55 PM showed "Note Text: CNA reported: 'Resident asked me if I wanted to lay on [his/her] groin, to which I replied 'No.' After that, [s/he] asked me if I knew somebody who would want to, and I replied, again, 'No.' Nurse educated resident." e. Review of a progress note dated 3/6/25 and timed 8:10 AM showed "Note Text: [Resident name] was sitting in the Great Room and asked a staff member what time [name], who plays guitar, will be here today. [S/He] was told 10:45. [Resident name] responded "Well I guess I will just have to find someone to play with my [genitals] until then." Staff member responded that we should not be speaking like that, [Resident name] was easily redirected." f. Review of a progress note dated 3/13/25 and timed 10:06 AM showed "Note Text: 3/8/2025 09:50 CNA documentation: resident came over to CNA kiosk on Birch North and asked if CNA could help [him/her] when asked with what he pointed to [his/her] groin area." g. Review of a progress note dated 3/18/25 and timed 9 AM showed "Note Text: [Resident name] was at the front of the building and when aide stopped to ask [him/her] what [s/he] is up to [Resident name] stated looking for someone to play with [his/her] private parts. I told [him/her] that it is not appropriate to say things like that." h. Review of a progress note dated 3/23/25 and timed 4:13 PM showed "Note Text: [Resident name] was up by the great room and asked me if I could help [him/her] and I asked with what [s/he] needs help with and then [s/he] had a smirk on [his/her] face and out [sic] [his/her] hand in the slit of [his/her] Pj bottom and was pulling on [his/her] privete part. I told [him/her] sorry no I can't help you with that." i. Review of a progress note dated 4/12/25 and timed 5:05 PM showed "Note Text: 4/11/2025 09:12 CNA documentation: I was informed by another resident that resident was being inappropriate at breakfast. Resident told [him/her] that [s/he] wanted [him/her] to touch [his/her] [genitals] during breakfast. Informed other resident to alert staff if it occurs again. Receiver calm and required no interventions." j. Review of a progress note dated 4/24/25 and timed 7:16 AM showed "Note Text: 4/23/2025 15:47 CNA	F0744		

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F0744 SS = D	Continued from page 10 documentation: Resident used inappropriate sexual innuendos. [S/He] said "come play with my [genitals]." [His/her] implication was to play with [his/her] [genitals]. [S/He] was disappointed that the [male/female] staff said no. HR [human resources], and two CNAs witnessed [his/her] behavior." k. Review of a progress note dated 5/16/25 and timed 11:59 AM showed "Note Text: Resident made comment to SW [s/he] is in need of finding a [gender] to 'play with [his/her] [genitals]'. SW [social worker] encouraged resident to reach out to [his/her] [spouse] if in need of intimacy." l. Review of an incident report dated 5/30/25 showed resident #41 reported resident #9 had touched his/her genitalia, in front of resident #41, before lunch. Resident #41 reported s/he told resident #9 "You're nasty, go away" and resident #9 left. Further review showed resident #41 reported s/he did not feel safe to the unit manager. Interview with resident #41 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 #41 to play with resident #9's genitals. Resident #41 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 #41 when s/he walked by and resident #41 did not feel it was playful; however, s/he revealed resident #9 had never grabbed resident #41. m. 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. 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	F0744		

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F0744 SS = D	Continued from page 11 conference. S/he did not recall who the nurses were that heard the incident. 2. Interview with the administrator and DON 9/11/25 at 11:43 AM revealed resident #9 spent a lot of time throughout the facility, liked to visit with people, and liked to watch activities. They revealed the resident was "pretty nosey" and was not well liked by other residents because s/he wants to know what they are doing, why they are doing it, and tell them why they are doing it wrong. The revealed the facility had offered resident #9 counseling, offered alone time in his/her room, offered magazines, worked with his/her spouse, set up weekly calls with his/her spouse because s/he won't come visit, and offered activities. They revealed the facility had completed staff education in response to comments and had identified issues happen more when s/he has been noted to have blood in his/her urine or pain with urinary obstruction. 3. Interview with the administrator and DON on 9/11/25 at 1:41 PM confirmed the resident's care plan was not fully developed for the resident's behaviors or facility interventions. 4. Review of the facility policy titled "Abuse Policy" last revised 5/2025 showed "...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..."	F0744		