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 09/03/2026

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 8/31/26 through 9/3/26. Also reviewed in the course of the survey were complaint intakes 2965016, 2984397, 3068442, 3068459, 3159268, and 3171212. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/23/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F0640	Corrective Action for Affected Resident(s): Resident #79's medical record and MDS assessment history were reviewed by the MDS Coordinator. The incorrect discharge assessment was inactivated as permitted by CMS requirements. The resident's census history and documentation related to the hospital transfer and return were also reviewed to ensure the resident's current census status and MDS assessment schedule were accurate. Corrective Action for Others: The MDS Coordinator/designee completed an audit of residents with hospital transfers and/or discharge return anticipated records for the previous 6 months to verify that residents who returned to the facility had the appropriate entry/reentry tracking record completed and transmitted as required. Any identified discrepancies were corrected in accordance with CMS MDS requirements. Systemic Changes to Prevent Recurrence: Licensed nursing staff, MDS staff and Business Office	09/25/2026

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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F0640 SS = D	Continued from page 1 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and MDS 3.0 Resident Assessment Instrument manual review, the facility failed to ensure a reentry assessment was performed for 1 of 25 sample residents (#79) reviewed. The findings were: 1. Review of medical record for resident #79 showed an unplanned discharge return anticipated MDS assessment dated 8/4/26 had been submitted. Further review of the resident's medical record failed to show an MDS readmission assessment had	F0640	Continued from page 1 Manager were educated regarding the appropriate census process for residents who temporarily leave the facility, including hospital transfers, discharge return anticipated, return to the facility, and the importance of accurate documentation of the resident’s departure and return. The facility implemented a process for the MDS Coordinator/designee to perform daily reconcilation with ADT census activity with MDS predicted scheduler to ensure discharges are accurate and meet the MDS requirements to identify Residents requiring an entry or tracking record. Increase crosstraining for census line adjustments for discharges and therapuetic leaves from facility. Monitoring to Ensure Ongoing Compliance: The MDS Coordinator/designee will audit residents with a discharge return anticipated and subsequent return to the facility to verify that the appropriate entry/reentry tracking record was completed and transmitted according to CMS requirements. Audits will be completed weekly x4 weeks, then monthly x2 months with findings reviewe/reported to QAPI committee.	09/25/2026

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F0640 SS = D	Continued from page 2 been completed. Review of the nursing progress notes failed to show when the resident had left the facility and when s/he had returned. 2. Review of the medical record showed an "After Visit Summary" from an acute care hospital showed "Narrowing of artery in neck, [dates] 8/4/26 - 8/5/26," 3. Interview with MDS coordinator and NHA on 9/3/26 at 10 AM revealed the nurse discharged the resident from the census and the system did not trigger the resident for reentry. The MDS coordinator confirmed the assessment had not been completed. 4. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual" version 1.20.1 last revised October 2025 showed "...Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility and was discharged return anticipated and returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an entry tracking record..."	F0640		09/25/2026
F0691 SS = D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents who required colostomy services, received such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 sample resident (#32) reviewed for ostomy care. The findings were: 1. Review of the 8/19/26 admission MDS assessment showed resident #32 had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Alzheimer's disease, depression, post-traumatic stress disorder, and parastomal hernia. Review of the physician orders showed the facility was to "change ostomy bag every morning and PRN [as needed]…Change ostomy	F0691	Corrective Action for Affected Resident(s): Resident #32's ostomy and surrounding peristomal skin were assessed by a licensed nurse to ensure the resident was receiving appropriate ostomy care and to identify any current concerns. The resident's physician orders, treatment administration record (TAR), care plan, and current ostomy care needs were reviewed to ensure the prescribed ostomy care was accurately reflected and available for staff documentation. Corrective Action for Others: The Director of Nursing/designee will identify all residents with an ostomy and review their physician orders, TAR, care plan, and documentation of ostomy care to verify that physician's orders, treatment administration record, care plan and current ostomy care needs are accurately reflected and available for staff documentation. Systemic Changes to Prevent Recurrence: The Director of Nursing/designee will verify via monthly audits that residents requiring routine ostomy care have appropriate orders and a designated location within the electronic medical record for staff to document completion of the ordered care. A batch order was created to standardize the order sets of any Resident with an ostomy device.	09/25/2026

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F0691 SS = D	Continued from page 3 wafer every 5 days if needed and PRN…" Review of the resident's care plan, dated 8/13/26, showed interventions to "...Monitor and change ostomy wafer every five days if needed & PRN…" The following concerns were identified: a. Review of the treatment administration record for 8/2026 and 9/2026 showed treatment orders to "Change ostomy bag every morning and PRN" and "Change ostomy wafer every five days if needed & PRN…" However, these treatment orders were not signed off as completed during the months of 8/2026 or 9/2026. b. Interview with the DON revealed the resident had orders for ostomy care; however, no routine had been set up in the electronic health record, so the treatment had not been signed off by nursing. Further interview revealed the DON's expectation was for staff to change the ostomy bag every day and change the ostomy wafer a minimum of every 5 days per Lippincott guidelines. c. Review of the policy titled "Colostomy and ileostomy, appliance care" with a review date of 12/14/25 showed, "...All pouching systems should be changed immediately if a leak develops…" Review of the manufacturer's instructions titled "Your Ostomy Pouching System and Wear Time" (accessed 9/8/26) on the Hollister website https://www.hollister.com/en/ostomycare/ostomylearningcenter/usingostomyproducts/yourpouchingsystemandweartime#, showed "A skin barrier is usually changed every three or four days (or about twice a week)."	F0691	Continued from page 3 Monitoring to Ensure Ongoing Compliance: The Director of Nursing/designee will audit residents receiving ostomy care to verify completion and documentation of ordered care. Audits will be completed weekly for 4 weeks and monthly for 2 months, or until substantial compliance is maintained. Results will be reported to the facility's Quality Assessment and Assurance/Performance Improvement Committee for review and recommendations.	09/25/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Corrective Action for Affected Resident(s): Resident #3 assessed by the licensed nurse for signs and symptoms of infection or other adverse outcomes related to the deficient practice.The staff member(s) involved in the observed wound care received education regarding appropriate hand hygiene, glove use, and infection prevention practices during wound care. Education included the requirement to perform hand hygiene at appropriate points during the wound care procedure, including before donning gloves and after glove removal, and whenever moving from a contaminated task to a clean task as indicated. Corrective Action for Others: The Infection Preventionist/DON/designee will complete observations of licensed nursing staff performing wound care to identify any additional concerns related to hand hygiene, glove use, clean/aseptic technique, and prevention of cross-contamination.	09/25/2026

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F0880 SS = D	Continued from page 4 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 4 Any deficient practice identified during these observations will be immediately corrected, and the staff member will receive additional education and/or competency validation. All residents on wound rounds had assessment by wound team for signs and symptoms of infection or other adverse outcomes. Systemic Changes to Prevent Recurrence: The Infection Preventionist/DON/designee will provide education to all licensed nursing staff who perform wound care. Education will include: Hand hygiene requirements during wound care, including appropriate hand hygiene before and after resident contact and before donning and after removing gloves. Appropriate glove changes and hand hygiene when transitioning between contaminated and clean portions of wound care. Prevention of contamination of wound-care supplies and the resident environment. Proper setup, handling, cleaning, and disposal of wound-care supplies and equipment. Monitoring to Ensure Ongoing Compliance: The Infection Preventionist/designee will conduct direct observations of wound care to monitor compliance with hand hygiene and infection-prevention practices. Audits will be completed on 3 wound-care procedures per week for 4 weeks, then 5 procedures per month for 2 months. Audit findings and trends will be reviewed by the Director of Nursing and Infection Preventionist. Results will be reported to the facility's Quality Assessment and Assurance/Performance Improvement Committee for review and recommendations.	09/25/2026

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F0880 SS = D	Continued from page 5 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 3 sample residents (#3) reviewed for wound care. The findings were: 1. Review of the quarterly MDS assessment dated 7/10/26 showed resident #3 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and diagnoses which included cancer, anemia, heart failure, diabetes mellitus, immunodeficiency, and rheumatoid arthritis. Review of a progress note, dated 8/27/26 and timed at 8 AM, showed the resident had a deep tissue injury to the right first metatarsal that measured 0.5 centimeters long by 0.3 centimeters wide and less than 0.1 centimeter deep. Review of the physician orders showed, “Wound Care: Right metatarsal joint: Cleanse. Apply collagen then bordered gauze one time a day for wound care.” Review of the care plan showed, “The resident has a risk for pressure injury…Administer treatments as ordered.” The following concerns were identified: a. Observation of wound care completed on 9/1/26 at 3:37 PM showed RN #1 failed to perform hand hygiene prior to donning personal protective equipment (PPE). After the RN removed the old dressing, he failed to change his gloves or perform hand hygiene before he proceeded to cleanse the wound with saline soaked gauze. While the RN was still wearing the same contaminated gloves, the RN retrieved a marker from his pocket, dated the new dressing, and returned the marker to his pocket. Further observation showed, the RN’s scissors, which were placed directly on the resident’s bed sheet during the procedure, were returned to the RN’s pocket without being cleaned or disinfected. Following the procedure, the RN doffed his PPE and discarded the used PPE in the trash can inside the room near the door and used hand sanitizer. b. Interview with RN #1 on 9/1/26 at 3:45 PM confirmed he did not complete hand hygiene prior to	F0880		09/25/2026

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F0880 SS = D	Continued from page 6 donning PPE, should have changed gloves after removing the old dressing, and should not have reached into his pockets while wearing contaminated gloves. c. Interview with the infection preventionist and the DON on 9/3/26 at 10:05 AM revealed it was the facility's expectation staff should have performed hand hygiene before wound care, after removal of the old dressing, and after wound care was completed. Further interview revealed the expectation was for any equipment or multi-use items used in the room should have been wiped down and cleaned. 2. Review of the Policy and Procedure titled “Wound dressing application, home care” revised 4/20/26 showed “...Perform hand hygiene. Put on gloves and, as needed, other personal protective equipment to comply with standard precautions…Remove the old dressing…Discard the soiled dressing…Perform hand hygiene. Put on new gloves…”	F0880		09/25/2026
F0887 SS = C	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration	F0887	Corrective Action for Affected Resident(s): Staff #1, Staff #2, and Staff #3 were all educated on the benefits and potential risks associated with COVID-19 vaccination. Corrective Action for Others: The facility developed/provided education to all current staff regarding COVID-19 vaccination. Education included the benefits and potential risks associated with COVID-19 vaccination and information regarding potential side effects. Systemic Changes to Prevent Recurrence: The facility's COVID-19 immunization policies and procedures were reviewed and revised as necessary to ensure staff receive required COVID-19 vaccination education in accordance with facility policy and regulatory requirements. Staff responsible for employee education and onboarding were educated regarding the requirements of F887 and the facility's revised process. All current staff were educated on the Covid 19 vaccination and all new hires will receive this education upon hire. Documentation of education will be maintained in employee compliance portal. Monitoring to Ensure Ongoing Compliance: The NHAdesignee will audit staff education records weekly for 4 weeks and monthly for 2 months to verify that required COVID-19 vaccination education	09/25/2026

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F0887 SS = C	Continued from page 7 of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on COVID vaccination education review, policy and procedure review, and staff interview, the facility failed to maintain documentation 3 of 3 staff members (staff #1, staff #2, staff #3) reviewed had received education on the benefits and potential side effects of the COVID-19 vaccination. The findings were: 1. Documentation of the education provided to 3 staff members on the benefits and potential side effects of the COVID-19 vaccination was requested from the facility on 9/1/26 at 5 PM. Interview with the NHA on 9/2/26 at 8:34 AM revealed no documentation was available. 2. Review of the policy and procedure "Immunizations and Immunity for Healthcare	F0887	Continued from page 7 has been completed and documented. Results will be reported to the facility's Quality Assessment and Assurance/Performance Improvement Committee for review and recommendations.	09/25/2026

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F0887 SS = C	Continued from page 8 Personnel", last revised 4/2025, failed to address the education of staff members on the benefits and potential side effects of the COVID-19 vaccination 3. Interview with the DON and infection preventionist on 9/3/26 at 9:52 AM confirmed education of staff members on the COVID-19 vaccination had not been conducted and the policy and procedure did not include the required information.	F0887		09/25/2026