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 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, 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 3/10/26 through 3/13/26. Also reviewed in the course of the survey were complaint intakes 2679309, 2696945, 2717801, 2789731, 2790328, and 2799621. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: certified nursing assistant BIMS: Brief Interview for Mental Status LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator POA: Power of Attorney RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		03/27/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	F0627	Corrective Action for Affected Resident(s) Resident #79 situation was immediately reviewed. Resident representative was contacted to determine interest in returning to the facility. Readmission offered to next available bed in accordance with federal regulations. Corrective Action for Others Facility conducted a review of all residents transferred to the hospital within last 90 days and concerns were immediately addressed.	04/09/2026

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

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 03/13/2026

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F0627 SS = D	Continued from page 1 (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i)	F0627	Continued from page 1 Systemic Changes to Prevent Recurrence Policy Revision to Transfer/Discharge and Bed-Hold Policy to include residents hospitalized retain return rights even after bed-hold expires. Residents are not considered new admissions upon return. Admission closures do not apply to return-rights of residents in acccordance with regulations. Staff education completed 4/9/26 on Policy and regulatory guideliness for discharge requirements. Monitoring to Ensure Ongoing Compliance Weekly audit of all hospitalized residents for 4 weeks, then monthly for 3 months. Results reported to QAPI committee Monthly.	

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F0627 SS = D	Continued from page 2 of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a 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 (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.	F0627		

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F0627 SS = D	Continued from page 3 §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning	F0627		

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F0627 SS = D	Continued from page 4 to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F0627		

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F0627 SS = D	Continued from page 5 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 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 10/13/25 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 10/13/25 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 12/9/25 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 12/19/25 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 10/13/25 with bed-hold notice and appeal rights. Resident remained continuously inpatient beyond 30	F0627		

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F0627 SS = D	Continued from page 6 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 10/13/25. d. Interview with the facility administrator on 3/12/26 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 10/13/25 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..."	F0627		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible	F0628	Corrective Action for Affected Resident(s) The facility reviewed transfer notices for residents #1, #3, #77, and #79 to ensure compliance with regulatory requirements. Education was provided to staff responsible for completing transfer notices to ensure that individualized, resident-specific clinical reasons are documented. No adverse outcomes were identified related to the transfers. Corrective Action for Others	04/09/2026

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F0628 SS = E	Continued from page 7 for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F0628	Continued from page 7 The facility conducted an audit of all transfer notices issued within the last 90 days to ensure inclusion of specific, individualized reasons for transfer or discharge. Any identified deficient notices were reeiwed and staff were re-educated. Systemic Changes to Prevent Recurrence The facility revised the “Notice of Transfer” form with a required flied prompting staff to document detailed clinical justification for transfer. Nursing Leadership will review all transfer notices prior to finalization. Education was provided to staff regarding transfer/discharge notice requrirements under federal regulations, including the requirement for individualized clinical reasons on 4/9/26. Transfer form included on annual comptenecies. Monitoring to Ensure Ongoing Compliance The facility will audit 5 transfer notices weekly for 4 weeks, then monthly for 3 months to ensure compliance with notice content requirements. Audit results will be reported to QAPI committee monthly for review and further action as needed.	

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F0628 SS = E	Continued from page 8 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and	F0628		

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F0628 SS = E	Continued from page 9 Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold	F0628		

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F0628 SS = E	Continued from page 10 policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: 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 10/13/25 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 10/13/25 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 12/9/25 and timed 2:20 PM showed "spoke with [name], POA regarding resident status. Resident has been out of facility	F0628		

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F0628 SS = E	Continued from page 11 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 12/19/25 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 10/13/25 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 10/13/25. e. Interview with the facility administrator on 3/12/26 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 12/21/25 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 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 12/21/25 showed the resident was provided a notice of transfer to an acute care facility due to his/her "needs cannot	F0628		

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F0628 SS = E	Continued from page 12 be met in the facility currently" and "their welfare is impacted." 3. Review of a progress note for resident #1 dated 12/21/25 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 12/21/26 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 01/28/26 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 3/12/26	F0628		

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F0628 SS = E	Continued from page 13 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.	F0628		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: 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 2/26/26 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.	F0644	Corrective Action for Affected Resident(s) Resident #6 was reviewed and referred for PASRR Level II evaluation following identification of a new qualifying mental health diagnosis. Corrective Action for Others The facility conducted an audit of all current residents to identify any diagnoses of serious mental illness, intellectual disability, or related conditions that may require PASRR Level II review. Systemic Changes to Prevent Recurrence The facility implemented a process requiring review of diagnoses at the time of MDS assessments, significant change assessments, and upon identification of new diagnoses to determine if PASRR Level II referral is required. Education was provided to nursing, MDS, SW, and admissions staff regarding PASRR requirements, including triggers for Level II referrals when new diagnoses of serious mental illness, intellectual disability, or related conditions are identified on 4/2/26. Monitoring to Ensure Ongoing Compliance The facility will audit all new admissions, MDS assessments, and diagnosis updates weekly for 4 weeks, then monthly for 3 months to ensure PASRR compliance.	04/13/2026

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F0644 SS = D	Continued from page 14 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.	F0644		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: 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 10/10/25 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:	F0679	Corrective Action for Affected Resident(s) Resident #68 was reassessed for activity preferences. The resident's interest in playing cards was confirmed, and individualized activity interventions were implemented, including offering and assisting the resident to participate in card games and 1:1 card activities. Corrective Action for Others The facility conducted an audit of all residents to ensure activity assessments are current and individualized preferences are reflected in care plans and activity programming. Systemic Changes to Prevent Recurrence Activity assessments will be completed on admission, quarterly, and with significant change. Implement structrured 1:1 activity program for residents unable to attend group activities, based on individual preferences. The activity calendar will be revised and updated monthly to reflect resident preferences. Staff education on person-centered activity programming to include: honoring resident preferences, offering verse documenting, 1:1 expectations. Monitoring to Ensure Ongoing Compliance Audit 5 residents weekly x 4 weeks, then monthly x 3 months. Findings will be presented to QAPI committee monthly.	04/13/2026

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F0679 SS = D	Continued from page 15 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	F0679		

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F0679 SS = D	Continued from page 16 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)..."	F0679		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 2/6/26 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	F0689	Corrective Action for Affected Resident(s) Comprehensive fall risk and supervision assessment of Resident #21, including review of cognitive status, environmental triggers, impulsivity and behavioral patterns. Care plan revised to relflect direct supervision during meals and in common areas, staff assisted seating and exit from dining table, heightened supervision during peak risk times (meals, transitions). Therapy evaluation ordered for safe seating and mobility strategies. Staff educated on updated interventions. Corrective Action for Others Audit of 100% of Residents with falls in the last 90 days and a BIMS score of 9 or less. Identified Residents care plans reviewed/updated as necessary for fall interventions and supervision levels for effectiveness Systemic Changes to Prevent Recurrence Implementation of Dining Room Supervision plan with one staff responsible for active monitoring during meal times. Post fall process to include a weekly review by IDT to include if interventions have been placed and effectiveness, with adjustment of interventions if proven ineffective. Staff education on fall prevention with a focus on supervision for cognitvely impaired residents, dining room safety risks and importance of intervention implementation vs. documentation.	04/30/2026

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F0689 SS = D	Continued from page 17 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…”.	F0689	Continued from page 17 Monitoring to Ensure Ongoing Compliance Dining room supervision audit: 5 observations per week x4 weeks, then weekly x2 months. High risk resident observation audit: verify supervision & interventions in place for 2 residents each weekx4 weeks, then monthly x2 months. Results reviewed in QAPI.	
F0744 SS = E	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F0744	Corrective Action for Affected Resident(s) Resident 63 care plan reviewed and updated to include enhanced supervision during meals, specific redirection	04/30/2026

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F0744 SS = E	Continued from page 18 §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 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 1/16/26 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	F0744	Continued from page 18 interventions during behavior of food scavenging for safety. Review of diet order, intake and weight. IDT review of current RCA and behavioral interventions and effectiveness. Resident 37 care plan updated to reflect desires for outside time duiring good weather and redirect tactics during times of poor weather not allowing for safe outside time. Corrective Action for Others All residents on secure dementia neighborhood (Cottonwood) reviewed for exit seeking, scavegening/food seeking, any identified concerns updated in care plans. Systemic Changes to Prevent Recurrence Implementation of continuous supervision in common areas at all times Residents are present. Education to staff on supervision and utilization of care plan for individualized interventions. Monitoring to Ensure Ongoing Compliance Dementia Care & Behavior Audit: Review of behavior documentation on Cottonwood, use of interventions and effectiveness. 5x/week x4 weeks, weekly x2 months. DIning room supervision audit as presented for F689.	

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F0744 SS = E	Continued from page 19 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 1/14/26 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	F0744		

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F0744 SS = E	Continued from page 20 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 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.	F0744		