STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 3/20/18. The survey was prompted by complaint intake WY00002580. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 610 SS=E	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.	F 610		5/13/18

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

Electronically Signed | 04/09/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 1 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 allegations of abuse were thoroughly investigated for 6 of 7 sample residents (#38, #39, #45, #53, #61, #63) involved in resident-to-resident altercations. The findings were: 1. Review of the 12/6/17 admission MDS assessment showed resident #61 was admitted on 11/29/17, had severe cognitive impairment, had diagnoses which included Alzheimer's disease and non-Alzheimer's dementia and showed no physical or verbal behaviors directed at others during the 7-day look back period. The following concerns were identified: a. Review of the facility's event report dated 12/19/17 showed resident #61 was involved in a "one on one with another resident." Further review showed the event details, which included a description of the behavior, behavioral symptoms, possible contributing factors, and interventions, had been left blank and the "evaluation" section stated the resident would be monitored for safety. Review of a progress note dated 12/19/17 showed the resident had walked up to a table where an activity was in progress and slapped a resident on the arm. b. Review of the facility incident report dated 12/19/17 named two residents (#39, #63) as being victims; however the description, investigation, and conclusion of the incident was left blank. c. The facility was unable to provide documentation of the incident and how each of the victims listed were affected.	F 610	The facility will ensure that all allegation of abuse are thoroughly investigated for all residents. 1a. The facility□s event report dated 12/19/17 involving resident #61 should have had the event detailed which included a description of the behavior, behavioral symptoms, possible contributing factors and interventions should not have been left blank, those areas should have been filled out by the person filling out the event. 1b. The facility incident report dated 12/19/17 naming two residents #39 and #63 as being victims, should have had the investigation and the conclusion of the incident filled out. 1c. The facility should have been able to provide documentation of the incident dated 12/19/17 and how each of the victims (#39 and #63) were affected. 1d. All residents could have been affected by the facility not filling out the incident repororts reports correctly or providing proper documentation on how victims were affected by resident to resident incidents. Going forward Douglas Care Center (DCC) will ensure that all resident to resident altercations are investigated thoroughly and correlating incident reports are filled out properly and documentation is completed for all residents involved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 2 2. Review of the 11/26/17 quarterly MDS assessment showed resident #39 had a BIMS score of 6/15 (severe cognitive impairment); had diagnoses which included Alzheimer's disease and non-Alzheimer's dementia; exhibited delusions; had verbal behaviors directed at others every day and of the 7-day look back period. The resident did not exhibit any physical behaviors directed at others during the look back period. The following concerns were identified: a. Review of the facility's event report dated 1/2/18 showed resident #39 was involved in a resident-to-resident altercation where s/he threw a tissue box at another resident which resulted in a skin tear. Further review of the event report showed the resident had physical behaviors directed toward others 1 to 3 days in the previous 7 days and verbal behaviors directed toward others which occurred daily. Non-pharmacological interventions of redirection and simplifying the environment were "effective." At the time of the survey (77 days after the incident) the "evaluation" section of the event report was marked as "N/A [not applicable]: event still open." b. Review of the facility incident report dated 1/2/18 included a description of the event; however this report failed to include investigative findings or a corrective action plan. 3. Review of the facility incident log for dates from 11/28/17 to 3/19/18 showed resident #45 was involved in a resident-to-resident altercations with resident #61 on 1/11/18 and 1/16/18. Further, the log indicated the resident was identified as the victim in both altercations. The following concerns were identified: a. Review of a progress note for resident #45 dated 1/11/18 showed "Resident was walking down the hallway when another resident passed	F 610	1e. All staff that is responsible for incident reports of resident to resident altercations will be educated on the proper procedure for filling out resident to resident altercation incident reports and the corresponding documentation. 2a. The incident dated 1/2/18 involving resident # 39 should have had the evaluation section of the event report completed and the event should have been closed. 2b. All residents could have been effected by the evaluation section of the event report not being completed or the event not being closed. Going forward DCC will ensure that all resident to resident altercations are investigated thoroughly and the events are closed out after the investigations are concluded. 2c. All staff that is responsible for incident reports of resident to resident altercations will be educated on the proper procedure for filling out resident to resident altercation and closing events. 3a. On an incident that was dated 1/11/18 involving resident #45, resident #45 should have been placed on incident charting and or follow up. 3b. Incident that was dated 1/11/18 involving resident where #61 was standing over resident #45 and resident #45 retaliated after being struck by #61 first was an incorrect incident report and was reported incorrectly to facility therefore	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 3 [him/her]. Helping hand [staff member] heard resident yelling and ran to see what was happening. That's when the helping hand saw this resident kick the other resident in stomach and punch [him/her] in the face. The helping hand intervened and separated them. This nurse was promptly notified and assessed both resident [sic], no injuries noted on either resident." Further review of the progress note showed no evidence resident #45 was placed on incident charting or follow up. b. Review of an incident report submitted to the State Survey Agency dated 1/11/18 showed "[Resident #61] has been restless/combative with staff and agitated. [S/he] was standing over [Resident #45] and [Resident #45] was guarding [him/herself] by raising [his/her] knee after being struck by [resident #61] in the leg. [Resident #45] retaliated and kicked [resident #61] in [his/her] lower abdomen and hit [him/her] in the face before the CNA could separate them. No injury to either resident." Further, review of the "Summary of investigative findings" section showed "Resident does not display 3 symptoms to justify urine dip per the McGeers criteria. MD notified of behaviors." c. Interview with RN #1 on 3/20/18 revealed the 1/11/18 incident was reported to her by a CNA and there was no evidence that resident #61 instigated the altercation or hit resident #45 during the altercation. Further, it was confirmed that both residents were in the hallway and resident #61 was not "standing over" resident #45. d. Review of a progress note for resident #45 dated 1/16/2018 and timed 3:47 PM showed the resident was involved in a resident-to-resident altercation. Review of the State Survey Agency reporting log showed the facility reported an	F 610	reported incorrectly to state. 3c. Incident dated 1/16/18 the facility should have been able to provide documentation of the incident and how resident #45 and #61 were each of affected by the incident. 3d. All residents could have been affected by not being placed on incident charting or follow up charting, incorrect reporting of residents, inability to provide documentation of resident to resident altercation(s) and how resident to resident altercation(s) affect the resident□s involved. 3e. All staff that is responsible for incident reports of resident to resident altercations will be educated on the proper procedure for filling out resident to resident altercations and the importance of ensuring that the information on the incidents are correct and that there is follow up documentation done. 4a. There should have been documentation and incident follow up done on 1/16/18 and 1/17/18 for resident to resident altercations involving residents #61 and #53. 4b. The facility should have been able to provide documentation of the incidents and how residents #61 and #53 were affected by the resident to resident altercations. 4c. All residents could have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 4 altercation involving resident #45 on 1/16/18. e. The facility was unable to provide documentation of the incidents and how each of the victims listed were affected. 4. Review of the facility incident log for dates from 11/28/17 to 3/19/18 showed resident #53 was involved in resident-to-resident altercations with resident #61 on 1/14/18, 1/16/18, and 1/17/18. The following concerns were identified: a. Review of the progress notes for resident #53 between the dates of 1/14/18 and 1/17/18 showed the facility documented a resident-to-resident altercation on 1/14/18. There was no documentation of resident-to-resident altercations on 1/16/18 or 1/17/18 and there was no documentation of incident follow up. b. Review of the State Survey Agency reporting log showed the facility reported altercations involving resident #53 on 1/14/18, 1/16/18, and 1/17/18. c. The facility was unable to provide documentation of the incidents and how each of the victims listed were affected. 5. Review of the facility incident log for dates from 11/28/17 to 3/19/18 showed resident #38 was involved in a resident-to-resident altercation with resident #61 on 1/18/18. The following concerns were identified: a. Review of the progress notes for resident #38 showed no documentation of a resident-to-resident altercation on 1/18/18 and there was no documentation of incident follow up. b. Review of the State Survey Agency reporting log showed the facility reported an altercation involving resident #38 on 1/18/18. c. The facility was unable to provide documentation of the incident and how each of	F 610	affected by not providing proper documentation and incident follow up as well not providing documentation of how the residents involved in the resident to resident altercations were affected by the altercations. 4d. All staff that is responsible for incident reports of resident to resident altercations will be educated on the proper procedure for documenting and incident follow up for all residents involved in the altercation and how residents are affected by the altercation. 5a. On incident dated 1/18/18 involving resident #61 and #38 there should have been documentation of a resident to resident altercation as well as documentation of incident follow up. 5b. The facility should have been able to provide documentation of the facility incident and how each of the victims #61 and #38 were affected. 5c. All residents could have been affected by not providing proper documentation and incident follow up as well not providing documentation of how the residents involved in the resident to resident altercations were affected by the altercations. 5d. All staff that is responsible for incident reports of resident to resident altercations will be educated on the proper procedure for documenting and incident follow up for all residents involved in the altercation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 5 the victims listed were affected. 6. Interview with the administrator on 3/20/18 at 4 PM revealed the facility did not have incident reports for the altercations at the facility and incident reports should be completed for all allegations of abuse including resident-to-resident altercations. Further, it was revealed the facility should have conducted an investigation, performed an interdisciplinary review to identify interventions, and completed follow up documentation on residents involved in resident-to-resident altercations. 7. Review of the policy titled "Detecting, Preventing and Reporting Abuse, Neglect, Mistreatment of Residents or Misappropriation of Resident Property" dated 3/2018 showed "...5. The Facility shall continually take steps to detect and prevent resident mistreatment, neglect or abuse, including injuries of unknown source, or misappropriation of resident property. Such steps include, but are not limited to:...d. identifying, correcting and intervening in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur, including, but not limited to, through [sic] resident assessment, evaluation and care planning...8. Upon a report of any incident or suspected incident of resident mistreatment, neglect or abuse, including injuries of unknown source, or misappropriation of resident property being made to the Facility, the Facility shall immediately begin investigating such reports and report the incident other [sic] official in accordance with Wyoming state law through established procedures, including to the State survey and Certification Agency. The facility shall keep documentation and show that all alleged violations are thoroughly	F 610	and how residents are affected by the altercation. 5e. All resident to resident altercations will be monitored by the NHA or designee and brought to QAPI to ensure that all incident reports, events, follow documentation, and effects on residents are completed and completed in a timely fashion. 6a. The NHA or designee will meet with the IDT the following business day after an incident to ensure that the interventions that were put in place at the time of the incident are effective and ask ourselves why this happened five times to ensure that the interventions put in place are working as interventions for all residents involved in the incident(s). 6b. The incidents will be monitored on a monthly basis to ensure that there are interventions in place and effective. The NHA or designee will bring all resident to resident altercations to QAPI until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 610	Continued From page 6 investigated, and shall document steps taken to prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his/her designated representative. If the alleged violation is verified appropriate corrective action must be taken..."	F 610		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure appropriate behavioral interventions were developed and implemented for 1 of 7 sample residents (#61) involved in resident-to-resident altercations. The findings were: 1. Review of the 12/6/17 admission MDS assessment showed resident #61 was admitted on 11/29/17, had severe cognitive impairment, had diagnoses which included Alzheimer's disease and non-Alzheimer's dementia, and showed no physical or verbal behaviors directed at others during the 7-day look back period. a. Review of the facility's event report dated	F 740	The facility will ensure appropriate behavioral interventions are developed and implemented. 1a. The facility□s event report dated 12/19/17 involving resident #61 should have had the event detailed which included a description of the behavior, behavioral symptoms, possible contributing factors and interventions should not have been left blank, those areas should have been filled out by the person filling out the event. 1b. The facility□s event report dated	5/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 740	Continued From page 7 12/19/17 showed resident #61 was involved in a "one on one with another resident." Further review showed the event details, which included a description of the behavior, behavioral symptoms, possible contributing factors, and interventions, had been left blank and the "evaluation" section stated the resident would be monitored for safety. Review of a progress note dated 12/19/17 showed the resident had walked up to a table where an activity was in progress and slapped a resident on the arm. b. Review of the facility's event report dated 1/2/18 showed resident #61 was involved in a resident-to-resident altercation where resident #39 threw a tissue box at him/her which resulted in a skin tear. c. Review of the facility's event report dated 1/11/18 showed resident #61 was hit on the side of his/her face and kicked in the stomach by another resident. d. Review of the facility's event report dated 1/14/18 showed resident #61 walked up behind a resident and struck him/her on the back. Further review showed the event details, which included a description of the behavior, behavioral symptoms, possible contributing factors, and interventions, were left blank. At the time of the survey (65 days after the incident) the "evaluation" section of the event report was marked as "N/A [not applicable]: event still open." e. Review of the facility's event report dated 1/16/18 showed resident #61 struck another resident. Further review of the event report showed the resident had physical and verbal behaviors directed at others on a daily basis. Non-pharmacological interventions of redirection, simplifying the environment and special care unit were marked as somewhat effective and described as "redirection is effective but lasts a	F 740	1/14/18 regarding resident #61 should have had the event details which included a description of the behavior, behavioral symptoms, possible contributing factors and interventions filled out and not left blank. The event should have been closed and not left open. 1c. The facility should have conducted an investigation and performed an interdisciplinary review to identify appropriate interventions for resident #61□s behaviors. 1d. All residents could be affected by the facility not conducting, investigating and performing an interdisciplinary review to identify appropriate interventions of all residents who are disciplining behaviors. 1e. The IDT will be educated that when a resident is exhibiting behaviors that the facility will conduct, investigate and perform an interdisciplinary review to identify appropriate interventions for that residents particular behavior; essentially conducting a root cause analysis and asking ourselves five times why it is happening. 1f. The NHA or designee will monitor that all resident to resident altercations incident reports are filled out and completed and there are no spots left blank and that all events are closed and not left open. All resident to resident altercations will have an investigation that will include an interdisciplinary review to identify appropriate interventions for that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 740	Continued From page 8 short duration." The "evaluation" section of the event report showed "no injury noted." f. Review of the facility's event report dated 1/17/18 showed resident #61 struck another resident. Further review of the event report showed the resident had physical and verbal behaviors directed at others on a daily basis. Non-pharmacological interventions of redirection, simplifying the environment, special care unit, and behavior management program without restraints were marked as somewhat effective with no further description offered. The "evaluation" section of the event report showed "no injury noted." g. Review of the facility's event report dated 1/18/18 showed resident #61 was involved in a resident-to-resident altercation. Further review of the event report showed "Resident's behavior impacts others by disrupting activities, mealtime, and quiet time. [S/he] is in constant motion, walking up and down the hall, going into other's rooms, waving [his/her] hands in other residents faces, touching them and speaking inappropriately/aggressively to others." Interventions for this event were marked as ineffective and described as "Redirecting resident to [his/her] room-with the door open-sitting with [him/her] calmed [him/her] for approximately 20 minuets (sic). [His/her] aggressive behavior started again and [s/he] is threatening staff and residents." The "evaluation" section of the event report showed "no injury noted." h. Review of the care plan for resident #61 under the category of "Behavioral Symptoms" showed the resident had behavioral problems that affected others. The approach included having staff intervene and monitor the behaviors, call the physician if necessary, and be placed on a restorative program.	F 740	particular resident□s behavior are appropriate. The result of the monitoring will be brought to QAPI for three months or until resolved. 1g. The NHA or designee will meet with the IDT the following business day after an incident to ensure that the interventions that were put in place at the time of the incident are effective and ask ourselves why this happened five times to ensure that the interventions put in place are working as interventions for all residents involved in the incident(s). 1h. The incidents will be monitored on a monthly basis to ensure that there are interventions in place and effective. The NHA or designee will bring all resident to resident altercations to QAPI until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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
F 740	Continued From page 9 i. Review of progress notes from 1/2/18 through 1/19/18 showed the resident had 10 incidents of physical aggression directed toward staff and residents. Interventions noted included changes to his/her medication regimen and placing the resident on a restorative program. 2. Interview with the administrator on 3/20/18 at 4 PM revealed the facility should have conducted an investigation and performed an interdisciplinary review to identify appropriate interventions for the resident's behaviors.	F 740		