STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	**333 N BRIDGER AVE PINEDALE, WY 82941**

(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 4/6/21 through 4/7/21. The survey was prompted by complaint intakes WY 00003209 and WY 00003212. In addition, a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys on 4/6/21 through 4/7/21. Based on the findings of the survey team, there were no deficiencies identified related to the infection control survey. The following common abbreviations are used throughout this document. MDS: Minimum Data Set BIMS: Brief Interview for Mental Status DON: Director of Nursing MD: Medical Doctor	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		4/30/21

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

Electronically Signed | 04/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	**333 N BRIDGER AVE PINEDALE, WY 82941**

(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 600	Continued From page 1 by: Based on medical record review, staff and resident interview, and review of facility policies and procedures the facility failed to ensure residents were free from unwanted sexual contact for 2 of 2 abuse investigations reviewed (involving residents #6 and #7). The findings were: 1. Review of the quarterly MDS assessment dated 3/22/21 showed resident #7 had a BIMS score of 14 of 15 indicating the resident was cognitively intact. The following concerns were identified: a. Review of the progress note dated 3/18/21 at 2:23 PM showed another resident walked up behind him/her, called him/her "sweetie" and kissed the residents neck. The other resident (#5) then reached inside resident #7's shirt and grabbed his/her breast. Resident #7 said, "You get your hand out of there." This progress note was entered by the DON. b. Interview with activity aide #1 on 4/7/21 at 10:20 AM revealed she was doing a craft activity with resident #7 on 3/18/21 in the sun room, when resident #5 leaned over from the back of the chair, whispered in resident #7's ear, kissed his/her neck and slid his/her hand down the front of resident #7's shirt. It was not heard what was whispered, however resident #7 said, "Get your hand out of there" and seemed very upset. Activity aide #1 immediately told the nurses of the incident. c. Interview with the DON on 4/7/21 at 9:40 AM revealed the incident with resident #7 had occurred as described, the leadership staff investigated the incident, and resident #7 had been offered access to therapeutic counseling services, but declined.	F 600	F600 The facility failed to meet the requirements of F tag 483.12 Freedom from Abuse, Neglect, and Exploitation as evidenced by negative resident to resident interaction on 03/18/2021, during which time resident # 5 reached inside the shirt of resident #7 during an activity, with staff present. Further, resident #5 repeated the behavior on 04/03/2021 to resident #6. To ensure the initial safety of resident #7, LCSW performed an evaluation of resident #5 and determined resident #5 did not pose a significant future risk. However, the incident did recur on 04/03/2021. At that time, facility placed resident #5 on 1:1 cares to promote the safety of other residents. A complete medical work up occurred to investigate possible causes. To prohibit further incidents, facility found alternate living arrangements for resident #5, in a facility more appropriate for resident #5□s needs. In addition, the facility□s activities department will escort residents to appropriate seating when starting an activity. Residents who come into an activity after initiation will also be assisted to their seats. Staff received education regarding process improvements on 04/27/2021. DON will report as a function of QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	**333 N BRIDGER AVE PINEDALE, WY 82941**

(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 600	Continued From page 2	F 600		

d. Interview with the resident on 4/6/21 at 11:30 AM revealed s/he "Never had any problems with the other residents here."

2. Review of the quarterly MDS assessment dated 2/12/21 showed resident #6 had a BIMS score 15 of 15 indicating the resident was cognitively intact. The following concerns were identified:

a. Review of the progress notes for resident #6 showed on 4/3/21 s/he was sitting alone in the sun room when resident #5 came up behind him/her, wrapped his/her arms around his/her upper body and grabbed his/her breasts. Resident #6 said, "No, No, No!." Resident #5 left the sun room. The facility staff was immediately informed of the occurrence.

b. Interview with resident #6 on 4/6/21 at 11:45 AM revealed s/he feels residents are treated well, with respect, and s/he feels safe in the facility. The resident stated, "I know that another person got attacked. I was sitting in the sun room and [s/he] came up behind me, put [his/her] arms around me and grabbed my breasts. I told [him/her] No! No! and [s/he] left the room. I told the aide and she told the nurse. I don't think anyone saw it happen." The resident further revealed s/he had not been bothered since.

c. Interview with the DON on 4/7/21 at 9:40 AM revealed she had done the preliminary investigation on the incident and confirmed the incident between resident #5 and resident #6 did occur as reported on 4/6/21. The clinical leadership staff had not had time to meet and complete the investigation.

3. Review of the facility policy number 105 (revised on 1.2021) showed "(a)ii sexual abuse is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	**333 N BRIDGER AVE PINEDALE, WY 82941**

(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 600	Continued From page 3 non-consensual sexual contact of any type with a resident." The policy also showed "It is [the facility's] policy that each resident well be free from abuse. Residents will be protected from abuse, neglect, and harm while they are residing at the facility."	F 600		