STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 82801**

(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 6/30/21 to 7/1/21. The survey was prompted by complaint intake WY00003247. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys on 6/30/21 through 7/1/21. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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.	F 600		8/14/21

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

Electronically Signed | 07/23/2021

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of policy and procedures, and review of incident reports, the facility failed to ensure residents were protected from unwanted sexual touching for 1 of 5 residents (#1) reviewed for abuse. The findings were: Review of the 6/16/21 facility reported incident (#2021-1809) involving residents #1 and #2 showed resident #2 inappropriately touched resident #1 under the shirt on the breasts while in the dining room. Resident #2, who was mobile in his/her wheelchair, was removed from the area by staff who observed the incident and took the resident to the activity room. The staff member notified the nurse of the the incident and the location of resident #2 in the activity room. Resident #1 remained in the dining room eating. The incident report showed the time of the occurrence was 5:15 PM. Continued review showed resident #2 returned to the dining room and again touched resident #1 on the breasts. There was no time entered for when the second incident occurred. The report showed the facility administrator reported the incident to the survey agency on 6/16/21 at 6:28 PM. The report further showed both residents were "severely demented" and were unable to recall the events. "[Resident #1] continued to eat during these events and was not injured nor did [s/he] exhibit any signs or	F 600	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual 1. Resident #4 was reported and investigated for unwanted sexual touching of resident #5 on 06/16/21. No other reportable occurrences have taken place and no negative outcomes have resulted in the incident. 2. Any resident involved in allegations of resident to resident altercations are at risk of the facility failing to protect the resident involved in the altercation. 3. All staff will be educated on the requirement to separate the residents involved in any altercation immediately as well as implementing interventions to	

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F 600	Continued From page 2 symptoms of fear or withdrawal." Review of the 6/11/21 quarterly MDS assessment showed resident #1 had a diagnosis of dementia and required supervision with set up help only for walking and locomotion. The assessment further showed no behaviors, and severe cognitive impairment with a BIMS score of 0/15. Review of the 5/1/21 quarterly MDS assessment showed resident #2 had a diagnosis of dementia and required extensive assistance with transfers and locomotion on the unit. Walking and locomotion off the unit did not occur. The assessment further showed the resident had no behaviors, and had severe cognitive impairment with a BIMS score of 0/15. Review of the care plan for resident #2, updated on 6/30/21, showed it included 1 to 1 staff supervision of the resident when up in his/her wheelchair to prevent any further behaviors of inappropriate touching. The following concerns were identified: a. Interview with CNA #1 on 6/30/21 at 4:30 PM confirmed she observed the incident in the dining room and took resident #2 to the activity room and reported to LPN #1. She stated she then returned to the dining room and was assisting another resident with eating when she saw resident #2 again in the room with his/her hands up resident #1's shirt. She intervened and moved the resident back to his/her room, notified the nurse and the resident was transferred from the wheelchair into the recliner. The CNA stated both residents were confused and this was not usual behavior for resident #2. She was unaware of any previous incidents involving the resident touching others inappropriately. She stated resident #2 continued to stay at the table and eat, and did not appear to be affected. b. Interview with LPN #1 on 6/30/21 at 4:40 PM confirmed the CNA had informed her of the	F 600	ensure safety of all residents. ED and DON will be notified directly after involved residents are separated. Staff will receive education on the definition of what constitutes an adverse event including actual or suspected abuse, resident to resident altercations and how to avoid deficient practices related to resident safety by providing 1:1 monitoring as necessary. Nurses will be educated on evaluating skin, pain and any negative effects following the incident and every shift for 72 hours for each resident affected. 4. A 100% audit of resident to resident altercations will be conducted by the ED, DON or designee to ensure policies and procedures have been followed, including timely reporting to ED and DON, separation of residents, implemented interventions and documented assessments of each affected resident. This audit will occur weekly for 4 weeks then monthly thereafter for three months. If any problem is noted, immediate re-education and/or corrective action will take place. Regional team will review any investigated allegations to ensure facility is in compliance. 5.Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until substantial compliance has been met. Performance improvement meetings consistent of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to	

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F 600	Continued From page 3 incident and made her aware resident #2 was in the activity room. The nurse stated she saw the resident start to wheel out of the room; however, she "didn't think [s/he] would do it again." She verified she was not aware the resident had gone back to the dining room. When she was informed of the second incident, the resident was transferred from the wheelchair to the recliner in his/her room and she notified the DON. She was not sure how much time elapsed between incidents. c. Review of the progress note dated 6/16/21 at 9:47 PM for resident #1 showed LPN #1 noted the incident and documented the inappropriate touching had occurred twice. The note showed resident #1 continued eating and "...did not appear to be affected negatively. DON [director of nursing] notified." The note did not include any assessment or details related to the resident's physical or psychological state. Further review of the medical record failed to show any physical assessment was completed of the resident following the incident. d. Review of the medical record for resident #2 showed a progress note dated 6/16/21 at 9:39 PM where LPN #1 noted the resident's involvement in the incident. The note did not include any assessment or details related to the resident's physical or psychological state. Further review of the medical record failed to show any assessment was completed for this resident following the incident. e. Interview with the nursing home administrator on 6/30/21 at 5:03 PM confirmed she was uncertain of how much time elapsed between the two incidents in the dining room. She stated they occurred "back to back." She further verified she was notified by the DON and made the initial report to the state agency that evening	F 600	which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies.	

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F 600	Continued From page 4	F 600		

regarding the resident to resident sexual abuse investigation. The interventions put into place to protect residents was the initial removal of the resident from the dining room and the one to one staff supervision after the 2nd incident occurred. This intervention became part of the resident's care plan to be implemented when s/he was up in the wheelchair. The administrator further verified the investigation showed it was an unusual event and the resident had no previous inappropriate behaviors with others. She confirmed there was no specific monitoring done after the incident, and resident #2 was determined to be unaffected. She stated if nursing assessments were completed after the incident they would be included in the medical records. She would check with her DON who was unavailable at that time. Interview with the administrator on 7/7/21 at 9:08 AM verified there were no nursing assessments completed for either resident related to the 6/16/21 incidents.

f. Review of the "Protection of Residents: Reducing the Treat of Abuse & Neglect" policy and procedure last reviewed on 4/15/19 showed the topic "Investigation and Protection" included "...9. If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure safety of all residents." In addition, the topic "Reporting and Response" included "...8. The charge nurse will immediately assess the resident and offer medical attention, if necessary. Findings of the assessment and any treatment provided will be documented in the resident's medical record. "