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 _____	06/30/2021

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/27/21 to 6/30/21. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted from 6/27/21 to 6/30/21. Based upon the findings of the survey team, no deficiencies were identified pertaining to the infection control survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		7/30/21

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

Electronically Signed | 07/18/2021

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure a individualized comprehensive care plan was completed for 2 of 12 sample residents (#17, #146). The findings were: 1. Medical record review showed resident #17 was admitted to the facility on 7/20/20 with diagnoses which included amnesic disorder due to known physiological condition-Korsakoff syndrome, restlessness and agitation, anxiety disorder, and Parkinson's disease. Review of the care plan showed the resident had a care plan for behavioral symptoms related to a history of wandering with a start date of 8/5/20. The approach, with a start date of 8/13/20, was "I was moved to the secure unit on 8/13/20 after I started wandering into other residents room. My [power of attorney] agreed I would be moved over there so that I could move about freely without having to be redirected constantly." Further	F 656	F656: Develop/Implement Comprehensive Care Plan: The facility will establish and maintain comprehensive care plans for all residents that are relevant to current stay and individualized. 1. Care plan team has been educated that any resident who discharges from the facility without plans to return, and then returns to the facility at a later date will have their old care plan discontinued and a new care plan put in place that will reflect the resident's current care needs and wants. 2. Resident # 17 will have their CP's updated. 3. Resident # 146 will have their CP's updated. 4. Care plans for all residents who have resident to resident altercations will be added to reflect specific interventions for staff to implement. Interventions that are	

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F 656	Continued From page 2 review showed a care plan for psychotropic drug use with a start date of 2/19/21. Approaches dated 2/19/21 were "My staff will monitor me for target behaviors of clonazepam including: agitated, aggressive, getting in residents personal space, restless" and "I will have GDR's [gradual dose reductions] attempted per my MD [medical doctor] order." The following concerns were identified: a. Review of a 6/21/21 progress noted timed 1407 [2:07 PM] showed, "Resident to resident altercation. Was 'working' with walker of another resident, other resident sitting in chair, this resident hit [him/her] around right eye, pulled top of hair and grabbed right wrist." Review of the resident's care plan showed a care plan for behavioral symptoms with a start date of 6/22/21 that described the problem as "At times I have agressive behaviors towards other residents and staff." The approach, with a start date of 6/22/21, was "I had a resident to resident altercation 6/11/2021. My staff will approach me in a calm and reassuring manner and attempt to redirect me away from other residents when I am in their personal space or attempting to touch their personal items as I allow. My doctor also added clonazepam to my medications." b. Review of the progress notes showed the following note on 6/26/21 at 13:28 [1:28 PM]: "CNA [certified nurse aide] reported this resident had attempted to choke female resident in dr [dining room], residents were immediately separated, resident calm in dr ambulating when nurse viewed around 1105 [11:05 AM]. DPD [local police department], on call manager and both of residents POA [power of attorney] or guardians were updated prior to 1120 [11:20 AM]. Starting Clonazepam the arrived from pharmacy." c. Interview on 6/29/21 at 3:49 PM with CNA	F 656	put into place that say the resident requires increased supervision will have a time frame for staff to follow (i.e., Q15 minutes) 5. A care plan will be added for all residents who utilize arm sleeves. A physicians order will also be obtained for all residents who have arm sleeves. 6. Care plans for all resident-to-resident altercations, re-admissions who left as return not anticipated, and for residents who have arm sleeves will be audited and results brought to QAPI monthly until resolved.	

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#2 revealed the following, "I was with the residents [#17, #20] in the secure unit dining area with [helping hand (HH) #1] at 11 AM on Saturday when [resident #17] came up behind [resident #20] and was aggressive, grabbing [him/her] on the neck. Within 2 seconds we pulled [resident #17] away. [Resident #20] appeared startled, but not injured. [Resident #17] has tried to be aggressive other times, and [s/he] wanders, so we cannot ensure [s/he] can be seen every minute.'

d. Interview with CNAs #1 and #3 in the secure unit on 6/30/21 at 9:98 AM revealed resident #17 was occasionally aggressive and was easily redirected. They each said the plan involved redirection and "keeping an eye on him/her." Each confirmed there was no one to one supervision of the resident, and no specific times for checks of his/her whereabouts.

e. Further review of the resident's care plan behavioral symptoms showed it was updated on 6/28/21 with a new approach. The new approach showed, "I had a recent resident altercation on 6/26/21. My doctor added 25mg of Seroquel [anti-psychotic medication] twice a day. I had a UA [urinalysis] that came back negative and blood work is still pending. My staff will continue to monitor my behaviors and report any changes to DON [director of nursing]." Observation in the dining area of the secure unit on 6/28/21 at 9:28 AM showed the resident was lethargic and unsteady, and CNA #1 was holding onto the resident's arm due to his/her unsteadiness. At that time, the CNA stated the facility had an order to reduce the resident's dosage of medication addressing aggressive behaviors because of the sedation effects.

f. Interview with the DON on 6/30/21 at 9:43 AM confirmed the care plan for resident #17 was

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not individualized regarding aggression and wandering to include supervision.

2. Review of the 6/28/21 admission minimum data set (MDS) assessment showed resident #146 had diagnoses which included coronary artery disease, heart failure, bilateral, localized edema, and cerebral infarction. Further review showed under "other skin problems" the resident had a skin tear. Observation on 6/28/21 at 12:11 PM showed the resident was wearing bilateral arm sleeves. Observation on 6/29/21 at 11:25 AM again showed the resident was wearing bilateral arm sleeves. Interview on 6/29/21 at 11:25 AM with the resident revealed the CNAs put both sleeves on daily to protect the skin, as his/her skin tore easily. The following concerns were identified:

a. Review of the care plan failed to show the bilateral arm sleeves were addressed.

b. Review of the physician orders failed to show an order for placement of arm sleeves.

c. Interview on 6/29/21 at 1:07 PM with the MDS coordinator revealed the resident was admitted with the arm sleeves on, and confirmed the care plan did not include the arm sleeves.

d. Review of the policy "Baseline Care Plan" reviewed/revised 3/29/18 showed ..."Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: ...b. Include the minimum healthcare information necessary to properly care for a resident..."