STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

(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 from 6/20/22 to 6/21/22. The survey was prompted by complaint intake WY00003401. The following common abbreviations are used throughout this document: MDS Minimum Data Set BIMS Brief Interview for Mental Status ADL Activities of Daily Living CNA Certified Nursing Assistant DON Director of Nursing	F 000		
F 656 SS=E	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).	F 656		8/5/22

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

Electronically Signed | 07/12/2022

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.

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F 656	Continued From page 1 (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 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 review of medical records, staff and resident interview, and review of policies and procedures the facility failed to ensure individualized, person-centered interventions were developed to address resident behavior for 2 of 5 residents (#1, #2) reviewed for resident-to-resident altercations. The findings were: Review of the admission MDS assessment dated 4/6/22 showed resident #2 was admitted with diagnoses which included anxiety disorder and Alzheimer's disease. Further review showed the resident had a BIMS score of 3 out of 15 signifying severe cognitive impairment. The resident was coded for behaviors of wandering with the risk of getting in dangerous places, with	F 656	The facility will ensure that care plans reflect person-centered interventions especially following resident-to-resident altercations. This will be accomplished by: 1) The DON, or designee, auditing the charts of current residents over the past 90 days and ensuring that any identified behaviors have individualized, person-centered interventions entered into their care plan. 2) The facility□s policy addressing Resident-to-Resident Altercations will be reviewed and updated accordingly by the DON. 3) The DON, or designee, will update Resident #2□s care plan to reflect individualized, person-centered	

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F 656	Continued From page 2 the wandering occurring daily. The resident was independent with ADLs. Review of the quarterly MDS assessment dated 5/24/22 showed resident #5 had diagnoses which included heart failure, chronic lung disease, weakness, pulmonary embolism and edema. The resident had a BIMS score of 14 of 15 signifying intact cognition. The resident was not coded for any behaviors. The resident was independent with all ADLs except dressing which required assistance. Review of progress notes for resident #5 from 4/4/22 through 5/16/22 showed documented occurrences of verbal and/or physical aggression towards other residents and staff. a. Review of a progress note dated 4/4/22 at 9:58 AM showed "Resident [#5] called [resident #2] a 'dumb son-of-a bitch' again." b. Review of a progress note dated 4/4/22 at 9:58 AM showed "Resident [#5] was guarding the exit door close to [his/her] room, as [s/he] does not like the alarm sounding, and [resident #2] attempted to exit, unknown what resident [#5] said but [resident #2] shoved [him/her] back into the wall and pinned [him/her] there, resident [#2] lifted [his/her] fist and shook it at [resident #5], there was no contact." c. Review of a progress note dated 4/9/22 at 5:38 showed "Resident [#5] kicked [resident #2] and caused [him/her] to fall to the floor on [his/her] knees and hit [his/her] face on the bedside table. CNA tried to stop [resident #5] from doing this and resident yelled at her." Review of progress notes dated 4/9/22 at 5:38 PM for resident #2 showed "Resident [#2] has been pacing and [s/he] wandered in to [resident	F 656	interventions that address the resident□s behaviors and safety. 4) The DON, or designee, will update Resident #5□s care plan to reflect individualized, person-centered interventions that address the resident□s behaviors or aggression. 5) New behaviors will be addressed at the monthly IDT meeting and individualized, person-centered interventions will be developed and implemented. 6) The results of the audit will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F656.	

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F 656	Continued From page 3 #5]'s room, where [resident #5] kicked [him/her] and knocked [him/her] to the floor on [his/her] hands and knees and hit [his/her] face on the bedside table, staff removed [resident #2] from room and did assessment, there were no injuries noted at this time." Interviews attempted on 6/20/22 at 3:44 PM with residents were unsuccessful. Resident #2 could not perform an interview and resident #5 refused interview. The following concerns were identified: 1. Review of the care plan goals for resident #2 dated 4/6/22 showed "I will not leave facility unattended through the review date. My safety will be maintained through the review date." Interventions included "Disguise back exits with bookcase sticker ...I wear a wander-guard ...monitor location every 15 - 30 mins." The care plan lacked individualized, person-centered interventions designed to address resident behaviors and safety. 2. Review of the care plan for resident #5 updated on 3/8/22 failed to show any individualized, person-centered interventions designed to address resident behaviors or aggression. 3. Interview on 6/21/22 at 1 PM with the DON confirmed resident #2 and resident #5 have had altercations, both verbal and physical. She stated resident #5 was told to have more understanding and avoid retaliating against resident #2. Additionally, resident #2's room had been changed. 4. Interview with the activity supervisor on 6/21/22 at 1:25 PM revealed there had been several	F 656		

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F 656	Continued From page 4 confrontational interactions between resident #2 and resident #5. It was stated resident #2 had no cognitive restraint mechanisms and resident #5 had aggression issues. The conflicts seemed unavoidable. It was confirmed that the care plan for resident #5 did not include any interventions to address aggressive behavior. 5. Review of the policy "Resident-to-Resident Altercations" dated 12/2007 showed "Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents." and review of the events will determine interventions to try to prevent additional incidents.	F 656		