STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 6/14/22 through 6/16/22. The survey was prompted by complaint intakes WY000033418 and WY00003420. The following common abbreviations are used throughout this document: ADL Activities of Daily Living BIMS Brief Interview for Mental Status CNA Certified Nurse Aide DNS Director of Nursing Services LPN Licensed Practical Nurse MAC Medication Aide Certified MDS Minimum Data Set RD Registered Dietitian 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		7/15/22

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

Electronically Signed | 07/08/2022

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F 600	Continued From page 1 involuntary seclusion; 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 provide adequate supervision and interventions to prevent abuse for 2 of 5 sample residents (#1, #2). The findings were: 1. Review of the quarterly MDS assessment dated 4/11/22 for resident #1 showed his/her BIMS score was 5 out of 15 which indicated severe cognitive impairment. The resident's diagnoses included Alzheimer's disease. Further review showed behaviors of delusions, verbal behavioral symptoms directed towards others for 1-3 days during the review period, and other behavioral symptoms not directed towards others for 1-3 days. Review of the quarterly MDS assessment dated 4/13/22 for resident #2 showed his/her BIMS score was 4 out of 15 which indicated severe cognitive impairment. Diagnoses included non-Alzheimer's dementia, anxiety, and depression. The following concerns were identified: a. Observation on 6/14/22 at 1:05 PM showed resident #1 and resident #2 in the same room with the door closed. Resident #1 had 2 bruises on his/her right hand and was walking around in the room. Resident #2 was sitting in a chair with a book in his/her hands. During interview with both residents at that time they each denied causing physical harm to one another. However, after leaving the room, the surveyor then overheard the residents cursing at each other and using profanity. Resident #2	F 600	Resident #1 and #2 will have audio surveillance placed in their room so staff can closely monitor for any escalations in behavior. Both residents are being separated after meals to allow alone time. Residents are monitored at least hourly to ensure needs are met and no escalations of behavior is noted. All residents have staff interaction upon rising before and after meals, throughout the day, evening, bed-time and every 2-3 hours at night to ensure safety. All residents will be reviewed to ensure individualized person centered interventions are in place and in the care plans. All manor staff will be educated on dementia signs and symptoms and how to de-escalate behaviors as well as documentation of such. Laminated cards will be in each resident room with their personalized interventions if a behavior arises. A weekly audit, using an audit tool, will be performed for 6 weeks, by the DON or designee to ensure that staff is aware of the personalized interventions for each resident. Immediate education will be completed at the time of audit if compliance is not 100% The results of the audit will be reported to the QAPI committee monthly. Resolution of this monitoring will occur when the QAPI committee determines 100% compliance.	

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F 600	Continued From page 2	F 600		

yelled at resident #1 for talking to the surveyor, stating, "you shouldn't have talked with her. Do you want to get us kicked out of here?" Resident #1 responded with profanity.

b. Review of the 5/25/22 at 11:22 PM progress note for resident #1 showed "physical aggression towards [spouse] [resident #2] was confused about why they were in a "hotel". [Resident #1] began yelling at [him/her] telling [him/her] to lay down and struck [him/her] across the left side of [his/her] face."

c. Review of the 6/1/22 at 4:36 AM progress note showed [resident #1] and [resident #2] had an argument that resulted in the two of them trying to push each other. They were quickly redirected and both of them tucked back into bed. No one was hurt."

d. Review of the care plan for resident #1 last revised 6/15/22 showed "behavioral symptoms-[resident #1] can be short with staff and get irritated with [spouse name]." Interventions were to administer medications as ordered by physician, leave hall door open and provide frequent checks to ensure no escalated behaviors are occurring, remove [resident #1 name] or [resident #2 name] if behaviors escalate until both are calm. Overnight if need be." In addition, "[resident #1 name] and [resident #2 name] do not want to be separated. Family doesn't want them separated."

f. Review of the 5/26/22 at 1:07 AM progress notes for resident #2 showed "resident and [spouse name] got in a fight overnight. Resident insisted on calling [daughter's name] and leaving after a fight with spouse, but calmed down after sitting and talking with staff. Resident went back to room to lay down around 12:00 AM. Resident is currently in the room packing [his/her] clothes 'to leave in the morning'. Attempted to redirect the

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resident multiple times, but could not get [him/her] to go to bed."

g. Review of the care plan for resident #2 last revised 4/20/22 showed "Cognitive Loss - [resident name] has both short term and long term memory problems. His/her short term memory is severely impaired." "Behavior- [resident name] can sometimes be tearful. S/he forgets why s/he is here and becomes upset when [s/he] realizes [s/he] cannot go home. [Resident] can get short with [resident #1] at times." Interventions included "monitor/document and or notify the nurse of any changes in my behaviors/mood. [Resident name] and [resident #1 name] do not want to be separated. Family doesn't want them to be separated. Leave door open and provide frequent checks to ensure behaviors do not escalate. Remove [resident name] or [resident #1 name] if behaviors escalate until both are calm overnight if need be)."

2. Interview with MAC #1 on 6/15/22 at 10:30 AM revealed both residents were independent with ADLs. It was normal for them to curse each other. She also stated when the residents were first admitted to the facility they would push each other.

3. Interview with LPN #2 on 6/15/22 at 11 AM revealed she checked on the 2 residents approximately every hour. She stated when the couple first moved in they would argue and there were physically aggressive behaviors. However, in the last 6 months it had gotten better.

4. Interview with CNA #1 on 6/15/22 at 12:50 PM revealed she saw resident #1 slap resident #2 in the face. She stated they were supposed to be getting ready for bed, and "We could hear them

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F 600	Continued From page 4	F 600		

arguing from the nurses station and went to check on them. We tried to redirect them and took [resident #2] out to the desk. [Resident #1's] left side of the face was pink from the slap, [s/he] was packing and wanted to go home after [s/he] slapped [him/her]. Almost all of [his/her] belongings were packed, and [s/he] was crying. [Resident #1's] aggression was scary".

5. Interview with the residents' daughter on 6/16/22 at 10:33 AM revealed there was no history of violence between the two residents. "They always work it out, and should stay together." In addition, she stated she thought Alzheimer's disease was a factor in what happened.

6. Interview with the DNS on 6/15/22 at 9 AM revealed staff were to check on the two residents every time they were passing the room, and the facility was trying to accommodate the residents' rights. She further stated when the two residents were out of their room, they "behaved".

7. Review of "Abuse/Neglect Policy" lasted reviewed 3/2021 showed ..."C. Prevention ... 4. Population...a. The facility provides identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors that might lead to conflict or neglect, such as...residents with a history of cognitive deficits, sensory deficits, aggressive behaviors...socially inappropriate behaviors, verbal outbursts,...b. The facility will ensure a comprehensive dementia management program to prevent resident abuse..."

8. Review of "Resident-to-Resident Altercations last reviewed 7/2021 showed "...2. ...d. Review

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F 600	Continued From page 5 the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents;"	F 600		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 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 develop and implement individualized person-centered behavioral interventions to ensure resident well-being for 2 of 4 sample residents with dementia (#1,#2). The findings were: 1. Review of the quarterly MDS assessment dated 4/11/22 for resident #1 showed his/her BIMS score was 5 out of 15 which indicated severe cognitive impairment, diagnoses which included Alzheimer's disease. Further review showed behaviors of delusions, verbal behavioral symptoms directed towards others for 1-3 days during the review period, and other behavioral symptoms not directed towards others for 1-3 days. Review of the quarterly MDS assessment dated 4/13/22 for resident #2 showed his/her BIMS score was of 4 out of 15, which indicated severe cognitive impairment and diagnoses which included non-Alzheimer's dementia, anxiety, and depression.	F 744	Resident #1 and #2 will have audio surveillance placed in their room so staff can closely monitor for any escalations in behavior. Both residents are being separated after meals to allow alone time. Residents are monitored at least hourly to ensure needs are met and no escalations of behavior is noted. All residents have staff interaction upon rising before and after meals, throughout the day, evening, at bed-time and every 2-3 hours at night to ensure safety. All residents will be reviewed to ensure individualized person centered interventions are in place and in their care plans. All manor staff will be educated on dementia signs and symptoms and how to de-escalate behaviors as well as documentation of such. Laminated cards will be in each resident room with their personalized interventions if a behavior arises. A weekly audit, using an audit tool, will be performed for 6 weeks, by the DON or	7/15/22

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F 744	Continued From page 6 Observation on 6/14/22 at 1:05 PM showed resident #1 and resident #2 in the same room with the door closed. Resident #1 had 2 bruises on his/her right hand. Resident #1 was walking around in the room. Resident #2 was sitting in a chair with a book in his/her hands. During interview with both residents at that time they each denied causing physical harm to one another. After leaving the room, the surveyor then overheard the residents cursing at each other using profanity. Resident #2 yelled at resident #1 using profanity and, stating, "you shouldn't have talked with her [the surveyor]. Do you want to get us kicked out of here?" Resident #1 responded back with profanity. Review of the 5/25/22 at 11:22 PM progress note for resident #1 showed "physical aggression towards [spouse] [resident #2] was confused about why they were in a "hotel". [Resident #1] began yelling at [him/her] telling [him/her] to lay down and struck [him/her] across the left side of [his/her] face...Resident appears to be getting angry with [spouse] when [s/he] is confused." Review of the 5/26/22 at 1:07 AM progress notes for resident #2 showed "resident and [spouse name] got in a fight overnight. Resident insisted on calling [daughter's name] and leaving after a fight with spouse, but calmed down after sitting and talking with staff. Resident went back to room to lay down around 12:00 AM. Resident is currently in the room packing [his/her] clothes 'to leave in the morning'. Attempted to redirect the resident multiple times, but could not get [him/her] to go to bed." Review of the 6/1/22 at 4:36 AM progress note for	F 744	designee to ensure that staff is aware of the personalized interventions for each resident. Immediate education will be completed at the time of audit if compliance is not 100%. The results of the audit will be reported to the QAPI committee monthly. Resolution of this monitoring will occur when the QAPI committee determines 100% compliance.	

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resident #1 showed [resident #1] and [resident #2] had an argument that resulted in the two of them trying to push each other. They were quickly redirected and both of them tucked back into bed. No one was hurt.

The following concerns were identified:

a. Review of the care plan for resident #1 last revised 6/15/22 showed "behavioral symptoms- [resident #1] can be short with staff and get irritated with [spouse name]." Interventions were to administer medications as ordered by physician, leave hall door open and provide frequent checks to ensure no escalated behaviors are occurring, remove [resident #1 name] or [resident #2 name] if behaviors escalate until both are calm. Overnight if need be." The care plan also noted "[resident #1 name] and [resident #2 name] do not want to be separated. Family doesn't want them separated." Person-centered, individualized behavioral interventions were lacking.

b. Review of the care plan for resident #2 last revised 4/20/22 showed "Cognitive Loss - [resident name] has both short term and long term memory problems. His/her short term memory is severely impaired." "Behavior- [resident name] can sometimes be tearful. [S/he] forgets why [s/he] is here and becomes upset when [s/he] realizes [s/he] cannot go home. [Resident] can get short with [resident #1] at times." Interventions included "monitor/document and or notify the nurse of any changes in my behaviors/mood. [Resident name] and [resident #1 name] do not want to be separated. Family doesn't want them to be separated. Leave door open and provide frequent checks to ensure

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behaviors do not escalate. Remove [resident name] or [resident #1 name] if behaviors escalate until both are calm overnight if need be)." Person-centered, individualized behavioral interventions were lacking.

c. Interview with MAC #1 on 6/15/22 at 10:30 AM revealed both residents were independent with their ADLs. It was normal for them to curse each other. Further, she stated when they first admitted to the facility they would push each other.

d. Interview with LPN # 2 on 6/15/22 at 11 AM revealed she checked on the 2 residents approximately every hour. Further, she revealed when the couple first moved in they would argue and there were physically aggressive behaviors. However, in the last 6 months it had gotten better.

e. Interview with CNA #1 on 6/15/22 at 12:50 PM revealed she saw resident #1 slap resident #2 on the face. She stated they were supposed to be getting ready for bed, and "We could hear them arguing from the nurse's station and went to check on them. We tried to redirect them and took [resident #2] out to the desk. [Resident #2] left side of the face was pink from the slap, [s/he] was packing and wanted to go home after [s/he] slapped [him/her]. Almost all of [his/her] belongings were packed, and [s/he] was crying. [Resident #1's] aggression was scary".

f. Interview with the residents' daughter on 6/16/22 at 10:33 AM revealed there was no history of violence between the two residents. "They always work it out, and should stay together." In addition, she stated she thought Alzheimer's disease was a factor in what

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happened.

g. Interview with the DNS on 6/15/22 at 9 AM revealed the staff were to check on the two residents every time they were passing the room, and the facility was trying to accommodate the residents' rights. She further stated when the two residents were out of their room, they "behaved".

h. Review of "Abuse/Neglect Policy" lasted reviewed 3/2021 showed ..."C. Prevention ... 4. Population...a. The facility provides identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors that might lead to conflict or neglect, such as...residents with a history of cognitive deficits, sensory deficits, aggressive behaviors...socially inappropriate behaviors, verbal outbursts,...b. The facility will ensure a comprehensive dementia management program to prevent resident abuse..."

i. Review of policy "Resident-to-Resident Altercations last reviewed 7/2021 showed "...2. ...d. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents;"