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 09/02/2022

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 8/25/22 to 9/2/22. The survey was prompted by complaint intake WY00003433. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	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 by: Based on medical record review, staff, resident	F 600	The facility will ensure that residents are	9/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/29/2022

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F 600	Continued From page 1 and resident representative interview, review of facility incident reports, and policy and procedure review, the facility failed to ensure residents were free from abuse for 1 of 4 residents (#1) reviewed for resident-to-resident altercations. This failure resulted in harm to resident #1 who experienced verbal abuse a reasonable person would have found humiliating, intimidating, demeaning, and degrading. The findings were: 1. Review of the 5/18/22 quarterly MDS assessment showed resident #1 was admitted to the facility on 8/5/21, had a BIMS score of 10/15 (moderate cognitive impairment), and had diagnoses which included moderate intellectual disabilities, unspecified psychosis not due to a substance or known physiologic condition, depression, and post-traumatic stress disorder. Further review showed the resident independently used a wheelchair for locomotion, and did not exhibit any behaviors, wandering, or rejection of care. Review of the 5/17/22 quarterly MDS assessment showed resident #2 was admitted to the facility on 2/1/21, had a BIMS score of 9/15 (moderate cognitive impairment), and had diagnoses which included non-Alzheimer's dementia and delusional disorders. Further reviewed showed the resident independently used a wheelchair for locomotion, exhibited verbal behaviors directed toward others 1 to 3 days of the 7-day look-back period, and exhibited behaviors not directed toward others every day of the 7-day look-back period. The following concerns were identified: a. Review of resident #2's medical record from 2/23/22 to 8/24/22 showed the following nurse progress notes with the following concerns:	F 600	free from abuse and neglect. This will be accomplished by: 1) The DON will re-educate staff on the definitions of abuse and neglect; this will include a presentation with pre- and post-test. 2) Abuse and neglect training will happen on a yearly basis and upon hire. 3) The DON has updated the Abuse, Neglect, and Exploitation policy per the new guidance set out by CMS. 4) The facility will identify triggers for resident #2 and add them to the care plan. Nurses will track behaviors every shift and document accordingly. Staff have been educated to keep resident #2 and resident #1 seated away from each other when in the same vicinity. 5) A formal complaint/incident log is being used to track any allegations of abuse/neglect/explotation. All staff have access to our reporting system and have been instructed to report anything that may represent abuse/neglect/explotation. 6) The DON, or designee, will present any allegations of abuse/neglect 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 F600.	

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F 600	Continued From page 2 i. Review of a 2/23/22 note showed several residents were watching a movie when resident #2 attempted to pull resident #4 away from resident #3. When resident #4 refused to move, resident #2 used a closed fist and hit him/her in the left arm and shouted "you do not need to be breathing all over [him/her] with your diseases." ii. Review of a note dated 3/11/22 showed resident #2 called resident #1 a "retard" and a "slut" and said, "[s/he] hasn't done anything with her life but color and that's a compliment". iii. Review of a 3/19/22 note showed resident #2 wheeled up behind resident #1 who was playing with a slot machine and said "we have to bow down to the queen" and other things that staff could not hear. iv. Review of a 3/28/22 note stated resident #2 was chasing resident #1 and yelled "you are a disgrace and should be ashamed of yourself because you are so fat". v. Review of a 4/22/22 note showed resident #2 had stated "the Dr. said I have dementia so my behaviors are excused." An additional note showed resident #2 told resident #1 to "put your boobs away you are acting like a whore". vi. Review of a 6/18/22 note showed resident #2 was hitting resident #1 with a clothing protector. vii. Review of 6/19/22 note showed resident #2 "kept going to the end of the hallway and looking into [resident #1's] room and mumbling intangibly, she then attempted to go into the front lobby looking for [resident #1] and became angry when redirected" Further the note stated resident #2 verbally attacked resident #1 when s/he entered the dining room. viii. Review of a note dated 7/7/22	F 600		

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F 600	Continued From page 3 showed resident #2 was "purposely" going up to resident #1 and trying to irritate him/her. ix. Review of a note dated 8/22/22 showed resident #2 pushed resident #1's wheelchair into the wall near the coloring poster. When resident #2 was redirected s/he pointed at resident #1 and stated "you fat asses are hippos like [s/he] is." b. Interview with CNA #1 on 8/25/22 at 10:23 AM stated resident #2 had developed an attachment to a resident of the opposite gender (resident #3) and followed him/her around the facility. c. Interview with CNA #2 on 8/25/22 at 10:54 AM revealed resident #2 had an obsession with resident #3 and would get jealous if resident #1 was near him/her. In addition, CNA #2 stated she thought resident #2 was "with it" cognitively and resident #1 was innocent in the altercations. d. Review of the "Resident Incident Report" forms received from the facility showed the only incident reported form documenting altercations between resident #1 and resident #2 was dated 6/18/22 and showed resident #2 was "hitting another resident [resident #1] with clothing protector during exercise." e. Interview with resident #1 on 8/25/22 at 11:10 AM revealed s/he did not know what was going on except that resident #2 thought s/he was flirting with resident #3 and would "glare" and "bump" into him/her. The resident stated s/he sat where the staff placed him/her and would be taken back to his/her room if resident #2 became upset. In addition, the resident stated s/he liked the facility because of all the activities the facility had. f. Interview with resident representative #1 on 8/25/22 at 11:44 AM revealed resident #2 was "mean" to resident #1 and would "kick", "hit" and	F 600		

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F 600	Continued From page 4	F 600		

was "bossy". Further the resident's representative stated the facility was not doing anything to stop the behavior and had told her "they just needed to work it out" and "you can always take [resident #1] out of the facility and put [him/her] someplace else."

g. Interview with resident representative #2 on 8/25/22 at 11:48 AM revealed she had witnessed resident #2 "kick", "hit", call resident #1 a "fat bitch", and told resident #1 which activities s/he could or could not do. The resident's representative stated she had also witnessed resident #2 "ramming" his/her wheelchair into the double doors to prevent resident #1 from leaving the facility.

h. Telephone interview with resident representative #3 on 8/31/22 at 5:10 PM revealed she was concerned about resident #1's safety and well-being, as resident #1 had been targeted by resident #2 for almost a year. The representative felt like the situation was getting worse with nothing being done about it. In addition, she had witnessed resident #2 knock down a Christmas tree in resident #1's room, bar the double doors so s/he could not leave the facility, throw plastic rakes, and push chairs into resident #1. The resident's representative stated resident #1 used to be more outgoing and now she felt the resident was more quiet and reserved.

i. Interview with dietary aide #1 on 8/25/22 at 12:10 PM stated she had witnessed resident #2 "get into" resident #1's face, throw a slot machine at him/her, and purposely run into other residents.

j. Interview with dietary aide #2 on 8/25/22 at 12:16 PM revealed she had witnessed resident #2 go into resident #1's room and take his/her possessions. In addition dietary aide #2 had witnessed resident #2 hit resident #1 with a

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F 600	Continued From page 5 "plastic kids shovel", call him/her multiple rude names, stare him/her down, try to isolate resident #1 by placing his/her wheelchair in front of resident #1's room and also block the double doors, which led out of the facility, so resident #1 could not leave. k. Telephone interview with the social worker on 9/2/22 at 8:20 AM revealed resident #2 was very protective of resident #3 which caused "obsessive behavior" when resident #1 was near him/her. She stated resident #1 was the main focus of behaviors exhibited by resident #2, however other residents were also affected at times. The social worker stated "all we can really do is supervise because of staffing" and we "talk" to resident #2 when s/he was being inappropriate. 2. Interview with the DON on 8/25/22 at 1:02 PM revealed resident #2 had an obsession with resident #3, and was jealous and showed behaviors when other residents were near him/her. The DON stated she did not think resident #2 intentionally targeted resident #1, however his/her behaviors were more directed at resident #1 than any other resident and occurred approximately 2 times per week. The DON stated the aggressive behaviors were better during the day when there was more staff. Further, the DON stated "this was no way to live or have to live" and had approached resident #1's family about transferring resident #1 to a different facility. 3. Review of the policy and procedure titled "Abuse and Neglect-Clinical Protocol & Guidelines" last approved on 2/2022 showed "...Treatment/Management 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 2. The	F 600		

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F 600	Continued From page 6 management and staff, with the support of the providers, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations...4. The provider and staff will address causes of problematic resident behavior where possible, such as mania, psychosis, and medication side effects."	F 600		
F 656 SS=G	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 rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		9/19/22

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F 656	Continued From page 7 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, resident, staff, and resident representative interview, medical record review, and policy and procedure review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 3 sample residents (#1, #2, #3) involved in resident-to-resident altercations. This failure resulted in harm to resident #1, who was not protected from another resident whose actions a reasonable person would find demeaning and humiliating. The findings were: 1. Review of the 5/18/22 quarterly MDS assessment showed resident #1 was admitted to the facility on 8/5/21, had a BIMS score of 10/15 (moderate cognitive impairment), and had diagnoses which included moderate intellectual disabilities, unspecified psychosis not due to a substance or known physiologic condition, depression, and post-traumatic stress disorder. Further review showed the resident independently used a wheelchair for locomotion, and did not exhibit any behaviors, wandering, or rejection of care. The following concerns were identified:	F 656	The facility will ensure that care plans are comprehensive. This will be accomplished by: 1) The DON, or designee, will audit care plans in conjunction with the MDS schedule to ensure each care plan is individualized. 2) DON has reviewed care plans for resident #1, #2, #3. 2) The MDS coordinator will audit all charts to ensure a review has been done. The MDS coordinator will then write a progress note when care plan reviews are complete. 3) The DON, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F656.	

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F 656	Continued From page 8 a. Interview with resident representative #1 on 8/25/22 at 11:44 AM revealed resident #2 was "mean" to the resident and would "kick", "hit" and was "bossy". b. Interview with resident representative #2 on 8/25/22 at 11:48 AM revealed she had witnessed resident #2 "kick", "hit", call the resident a "fat bitch", and would tell the resident which activities s/he could or could not do. The resident's representative stated she had also witnessed resident #2 "ramming" his/her wheelchair into the double doors to prevent the resident from leaving the facility. c. Telephone interview with resident representative #3 on 8/31/22 at 5:10 PM revealed she had witnessed resident #2 knock down a Christmas tree in the resident's room, bar the double doors so the resident could not leave the facility, throw plastic rakes, and push chairs into the resident. d. Interview with dietary aide #1 on 8/25/22 at 12:10 PM stated she had witnessed resident #2 "get into" the resident's face, throw a slot machine at the resident, and purposely run into other residents. e. Interview with dietary aide #2 on 8/25/22 at 12:16 PM revealed she had witnessed resident #2 go into the resident's room and take his/her possessions. In addition dietary aide #2 had witnessed resident #2 hit the resident with a "plastic kids shovel", call the resident multiple rude names, stare the resident down, and try to isolate the resident by placing his/her wheelchair in front of the resident's room and also block the double doors leading out of the facility so the resident could not leave. f. Review of nurse progress notes for resident #2 from 2/23/22 to 8/24/22 showed multiple instances where resident #2 had shown verbal	F 656		

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F 656	Continued From page 9 and physical aggression toward the resident. g. Review of the resident's care plan, last reviewed 6/7/22, showed no evidence a care plan had been developed to include interventions to protect the resident. 2. Review of the 5/17/22 quarterly MDS assessment showed resident #2 was admitted to the facility on 2/1/21, had a BIMS score of 9/15 (moderate cognitive impairment), and had diagnoses which included non-Alzheimer's dementia and delusional disorders. Further reviewed showed the resident independently used a wheelchair for locomotion, exhibited verbal behaviors directed toward others 1 to 3 days of the 7-day look-back period, and exhibited behaviors not directed toward others every day of the 7-day look-back period. The following concerns were identified: a. Interview with CNA #1 on 8/25/22 at 10:23 AM revealed the resident had some "rough" days, could be "ornery" and was attached to a resident of the opposite gender. The CNA stated when the resident was upset she would let the resident calm down and reapproach at another time. b. Interview with CNA #2 on 8/25/22 at 10:54 AM revealed the resident had an obsession with a resident of the opposite gender (resident #3) and would get jealous if resident #1 was near him/her. The CNA stated interventions included to keep resident #1 and resident #3 separated and to have the DON or the social worker speak with the resident when s/he was upset. c. Telephone interview with LPN #1 on 9/1/22 at 11:35 AM revealed interventions included 1-to-1 supervision and redirection. In addition LPN #1 stated when the resident's behaviors were escalating s/he could not be reasoned with. d. Review of the nurse progress notes from	F 656		

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F 656	Continued From page 10 2/23/22 through 8/24/22 showed multiple instances of verbal and physical aggression directed towards staff and residents; refusal of care; disruption of group activities; the use of intramuscular Ativan (antianxiety medication)"; adjustments in the resident's medication regimen; interference in the care of other residents; and entering other resident's rooms. In addition, the progress notes documented the obsession with resident #3 and noted on 3/21/22 the resident was "rubbing and kissing" on resident #3; 3/22/22 showed the residents were "inappropriately touching each other"; and on 3/28/22 showed the residents were "kissing and fondling". e. Observation on 8/25/22 at 12:03 PM showed resident #3 was seated next to resident #2 for the noon meal. Resident #3 was patting and holding resident #2's hand and was touching his/her leg. f. Review of the resident's care plan, last reviewed 6/16/22 showed no evidence a resident assessment had been completed and care planning interventions developed to address the resident's distressed physical, sexual, and verbal behaviors. 3. Review of the 5/26/22 quarterly MDS assessment for resident #3 showed the resident was admitted to the facility on 8/12/20, had a BIMS score of 3/15 (severe cognitive impairment), and had diagnoses which included depression. Further review showed the resident independently used a wheelchair for locomotion, and did not exhibit any behaviors, wandering, or rejection of care. The following concerns were identified: a. Interview with CNA #2 on 8/25/22 at 10:54 AM revealed resident #2 had developed an obsession with the resident and for the majority of	F 656		

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F 656	Continued From page 11 the time [resident #3] appeared to be "okay with it", however she had witnessed the resident push resident #2 away. b. Telephone interview with resident representative #3 on 8/31/22 at 5:10 PM revealed she had witnessed the resident push resident #2 away and state "you are not my wife". c. Review of nurse progress notes from 2/23/22 to 8/24/22 for resident #2 showed multiple notes related to resident #2's obsession with the resident. On 7/12/22 showed the resident attempted to move away from resident #2 and was yelling "NO NO NO" and on 7/25/22 resident #2 attempted to prevent the resident from participating in an activity and later attempted to enter the resident's room while care was being provided. In addition the residents had been observed "rubbing and kissing", "inappropriately touching", and "kissing and fondling". d. Review of the resident's care plan, last reviewed 6/16/22, showed no evidence a resident assessment had been completed and care planning developed to address the resident's sexual contact with resident #2 or what interventions were in place to protect the resident. 4. Interview with the DON on 8/25/22 at 1:02 PM confirmed the care plans were incomplete. 5. Review of the policy titled "Reviewing and Revising the Care Plan" last approved 12/2018 showed "...B. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. C. Procedure for reviewing and revising the care plan when a resident experiences a status change: 1. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if	F 656		

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 09/02/2022

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 656	Continued From page 12 applicable. 2. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. 3. the team meeting discussion will be documented in the nursing progress notes. 4. The care plan will be updated with the new or modified interventions. 5. Staff involved in the care of the resident will report resident response to new or modified interventions. 6. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. 7. The MDS Coordinator or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. 8. The MDS Coordinator or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs."	F 656		