DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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 3/30/23 to 3/31/23. The survey was prompted by complaint intake WY00003560.	F 000	This plan of correction and the responses to each F-tag are submitted to maintain certification in the Medicare Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	
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 and resident interviews, and review of facility documentation, the facility failed to protect the resident's right to be free from physical abuse by staff for 1 of 2 sample residents (#1) reviewed for abuse allegations. This failure resulted in physical and psychosocial harm to resident #6. The findings were: 1. Review of the 3/13/23 quarterly minimum data set (MDS) assessment showed resident #1 had diagnoses including traumatic brain injury, seizure disorder, and psychotic disorder, and scored a 15	F 600	F-600 Free From Abuse and Neglect 1) Resident #1 was immediately removed from harm's way to ensure safety. Resident #1 identified in this statement of deficiency for the incident of the allegation of abuse was reviewed and investigated. The allegation was reported to the State Agency, investigation was reviewed and completed, and care plan reviewed and updated. The resident was assessed for injuries. CNA #1 was immediately placed on administrative leave. 2) All residents residing in the facility that had received care from CNA#1 were assessed for potential signs of abuse. Care plans for all other residents who have the potential to be affected by the deficit practice will be reviewed and updated. All staff providing direct and indirect care have received training on the policy of Abuse Prevention. In addition, all nursing staff and Security staff received training in MANDT wheelchair techniques and MANDT restraint documentation. All applicable training materials have been revised to reflect the changes. All applicable policies and procedures have been reviewed and revised as indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine Szymanski	SNF Administrator	5/02/2023

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 600	Continued From page 1 out of 15 on the brief interview for mental status (BIMS) indicating intact cognition. Review of a progress note dated 3/6/23 showed the resident was displaying aggressive behavior towards staff. The note read "...A third staff member came in, and took [resident name] to the ground." 2. Review of the facility's "Client Right Investigation Report" showed an allegation of physical abuse which occurred on 3/6/23 at approximately 4:15 PM involving resident #1 and certified nurse aide (CNA) #1. The allegation was reported by staff #2. CNA #3 and CNA #4 were witnesses to the incident. Staff #2 stated he saw CNA #1 pull the resident out of the wheelchair and the resident hit his/her back and head on the floor. He stated he then saw the CNA hit the resident as the CNA sat on top of the resident. Further review of the report showed the facility's investigation conclusion was "Allegation of abuse is verified. There is enough evidence presented through written statements that [CNA #1] did in fact pull [resident] from [his/her] wheelchair by [his/her] leg/ankle, resulting in [resident] landing on the floor. It cannot be determined if that force caused any injuries. There is not enough evidence presented witness statements or pictures proving that [CNA #1] punched [resident.]" 3. Review of facility investigation documentation showed the following written statements: a. On 3/6/23 Staff #2 wrote "...witness a staff pull a client out of [his/her] wheelchair Cient hit [his/her] back and [his/her] head on the floor then the staff hit the client as he sat on top of [him/her]." b. On 3/7/23 CNA #3 wrote "...[resident] continued to hit and kick...[CNA #1] then grabbed	F 600	F-600 Free From Abuse and Neglect (con't) 3) To assure sustainability going forward, observation audits (i.e. staff resident interaction and provision of care in accordance to care plan) will be conducted to assure an incident does not reoccur. All residents that have behaviors that indicate harm to themselves and/or others will be assessed by the physician or medical provider. The resident care plans will identify appropriate interventions to address difficult behavior. Audits will be conducted to ensure that the appropriate interventions are in place and in the resident care plan. The audits will occur weekly x 4 weeks and monthly for 4 months. The results from the audit will be reviewed at the regularly scheduled QAPI meeting. 4) The updated training materials and the results from the audit will be reviewed at the regularly scheduled QAPI meeting. All investigated incidents will be reviewed and reported at the regularly scheduled QAPI meeting. Audit results and actions taken will be reported to the QAPI Committee and the Committees recommendations will be followed for 4 months. 5) The Administrator is responsible for compliance. 6) Date of Alleged Compliance is 5/25/23.	

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F 600	Continued From page 2	F 600		

[resident's] leg and started to pull [resident] out of [his/her] chair. When I realized what he was doing I tried to let [resident] down as easy as I could, so that [s/he] wouldn't be injured."

c. On 3/7/23 CNA #4 wrote "...[CNA #1] came in and grabbed [resident] by ankle and pulled [resident] out of wheelchair to floor and then held [resident] down..."

4. Further review of the facility's "Client Right Investigation Report" showed the resident was interviewed by the facility investigator and a Department of Family Services (DFS) caseworker on 3/9/23. The resident stated that staff beat him/her up but s/he could not remember their names. The resident was asked if s/he was punched and s/he said yes, but could not remember where. S/he said "maybe it was my side" but could not remember which side.

5. Review of a progress note by RN #5 dated and timed 3/6/23 at 5:20 PM showed at 5:10 PM she assessed the resident following the incident which showed "...2 purple bruises under the left upper arm. Bruise #1 is maroon in color, linear and approx 2 cm x 1 cm. Bruise #2 is round, light purple 2 cm x 2 cm." The note also showed the resident had superficial scratches to both arms which the resident stated was from self harm. There was also a superficial wound to the resident's forehead that "appears to be an old wound that may have been opened up..."

6. Further review of the "Client Right Investigation Report" showed registered nurse (RN) #5 met the facility investigator on 3/7/23 at 10:30 AM to assess resident #1. "There was a large blue, red and purple bruise and scrapes near the bruise on the mid to lower part of the ribcage area on the

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left side. When [RN] saw the bruise on [resident's] back she said "I didn't see that yesterday." [RN] asked [him/her] where [s/he] got the bruises and [resident] said from the staff-couldn't remember his name, beat him/herself up...We asked [resident] if [s/he] could show me [his/her] left arm near the inner bicep and tricep area. There were several bruises, different sizes, all appeared to be recent as they were red, blue and purple with several scratches on inner arm area and on armpit and one on chest area, close to the armpit. I photographed all bruising and scratches/scrapes...[RN] said that the bruising on [his/her] back was from when [s/he] was throwing [himself/herself] around in the wheelchair, as it would match up that part of [his/her] chair and that [s/he] throws [himself/herself] really hard."

7. On 3/30/23 at 3:17 PM CNA #3 was interviewed. He stated resident #1 was trying to hit and kick him/herself and CNA #4 while the resident was in the wheelchair. He stated CNA #1 grabbed the resident's leg and pulled and the resident landed on the floor. He stated he was surprised. He stated he had a hold of the top part of the resident and tried to lower the resident when that happened. He further stated CNA #1 did not say anything to them prior. He stated he did not see CNA #1 punch the resident.

8. On 3/30/23 at 3:23 PM staff #2 was interviewed. He stated he worked in supply and was in the house [facility] that day. He stated CNAs #3 and #4 were trying to keep resident #1, who had tried to leave in his/her wheelchair, in the house. He stated CNA #1 then walked over and grabbed the resident's leg and pulled. He stated the resident came out of the wheelchair

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and hit the floor. He stated the other CNAs had a hold of the upper part of resident at first, but the resident still hit the floor. He stated CNA #1 then hit the resident in the side with his fist while the resident was on the ground. He stated what he observed looked "very intentional" and was "straight up abuse to me."

9. During an interview on 3/30/23 at 3:35 PM CNA #4 stated during the incident resident #1 was swinging at them. He stated CNA #1 came in and got ahold of the resident by the ankle and pulled the resident onto the floor from the wheelchair. He described it as a "firm pulling motion" and stated the resident landed on his/her back. He stated he was shocked that happened. He stated there was no communication from CNA #1 prior to that. He did not observe the CNA hit the resident. He stated after the incident CNA #1 told him he thought the resident would be safer to deal with on the floor.

10. On 3/30/23 at 4:47 PM CNA #1 was interviewed. He stated that the resident did hit the floor when s/he came out of the wheelchair and "I was the unlucky one holding [her/him]." He stated he tried to communicate with the other CNAs by using his eyes (looked down to the floor) to show his intention that they should get the resident onto the floor from the wheelchair. He stated he didn't verbally say anything. He stated when the resident was kicking at him, the resident slid a little down in the wheelchair. He grabbed the resident's ankle and the resident slid out and landed on his/her back. He stated the other CNAs looked "dumb founded." He stated when the resident was on the floor s/he was trying to hit him, so he laid across the resident. He stated he did not hit the resident.

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F 600	Continued From page 5 11. On 3/31/23 at 9:13 AM resident #1 was interviewed. When asked how staff treated him/her, the resident replied "good except for the staff on the house, [name of CNA #1]." The resident stated that staff person "was suspended or fired, and I'm glad." During the interview, s/he described two incidents involving CNA #1. The resident mentioned being "grabbed out of the wheelchair" and stated "he punched me." The resident also mentioned being slammed into a wall. The resident did not know the dates. The resident stated after the second incident, s/he was taken to his/her room by security. The resident stated after the second incident s/he had bruising to the back which the facility took pictures of. The resident stated s/he has PTSD and "that added to it...nothing but nightmares since." 12. On 3/31/23 at 11:50 AM the nursing home administrator (NHA) stated since the incident staff received education. However, she stated the facility had not implemented any audits or monitoring and had not had a quality assurance (QA) meeting since the incident.	F 600		
F 604 SS=G	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604	It is the policy of Mountain View Skilled Nursing Community to ensure that all the residents remain free from abuse, neglect, misappropriation of property, exploitation, and ensure that all residents remain safe from harm. This includes freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical problems. F-604 Right to be Free From Physical Restraints 1) Resident #1 had the use of a safety smock removed from the care plan. The safety smock will only be applied with consent from the resident. The Director of Nursing and/or designee will implement measures to ensure that this practice does not reoccur, including updating the procedure on the use of the safety smock. 2) All nurses, CNA's, and security staff will complete competency-based training on the application of a safety smock. All applicable policies/procedures have been reviewed and revised to reflect the changes. The physician and/or medical provider will provide an order for an emergent MANDT hold and safety smock. All of the other CNA's in the home as well as security staff have received MANDT hold wheelchair techniques and MANDT hold documentation training, along with proper use of a Safety Smock. Policies on Suicide Threats and Behavioral Emergencies have been updated to include the process for obtaining an order from the provider for a safety smock and an order after a MANDT hold is applied.	

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F 604	Continued From page 6 §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, and policy and facility documentation review, the facility failed to ensure a restraint was the least restrictive alternative and used for the least amount of time for 1 of 1 sample residents (#1) with restraints, which resulted in psychosocial harm. The findings were: 1. Review of the 3/13/23 quarterly minimum data set (MDS) assessment showed resident #1 had diagnoses including traumatic brain injury, seizure disorder, and psychotic disorder, and scored a 15 out of 15 on the brief interview for mental status (BIMS) indicating intact cognition. The assessment showed the resident did not use restraints. Review of the facility's "Client Right	F 604	F-604 Right to be Free from Physical Restraints (con't) 3) To assure sustainability going forward, audits will be conducted to assure that orders for a safety smock and MANDT hold are completed and that the correct documentation is in place. Audits will also ensure that the appropriate interventions are in place and in the resident care plan. The audits will occur weekly x 4 weeks and monthly for 4 months. The results from the audit will be reviewed at the regularly scheduled QAPI meeting. 4) The updated policy and procedure on the safety smock will be reviewed at the Policy Committee. The audit results will also be reported at the QAPI meeting. Audit results and actions taken will be reported to the QAPI Committee and the Committees recommendations will be followed for 4 months. 5) The Administrator is responsible for compliance. 6) Date of Alleged Compliance is 5/25/23.	

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Investigation Report" for an incident on 3/6/23 showed "All security involved [security officers #1, #2, #3] assisted with putting [resident] in the suicide vest and stated that they have had no training on how to get it on and that they hold [resident] while staff put on the vest." The following concerns were identified:

a. Review of a written statement dated 3/7/23 by security guard #1 showed "...[security guard #2], [security guard #3)] and I assisted staff in getting [resident] into the smock. [Security guard #2] and I did a modified side body hug for [his/her] arms and [security guard #3] took care of [resident's] good leg."

b. Review of a written statement dated 3/7/23 by security guard #2 showed "...Received a call from [social worker] who said that [resident] needed to be placed in a suicide smock..."

c. Review of a written statement dated 3/7/23 by security guard #3 showed ..."[resident's] behavior escalated. Me and the other security guards assisted with the smock and side body support..."

d. Review of a written statement by certified nurse aide (CNA) #4 dated 3/7/23 showed "...Suicide vest was called for and the four of us applied the vest to [resident]. [Resident] resisted and fought against vest being applied."

e. Review of a progress note by RN #5 dated and timed 3/6/23 at 5:20 PM showed at 5:10 PM she assessed the resident following an incident. The resident was in a suicide smock at the time of the assessment. The nurse documented "...2 purple bruises under the left upper arm. Bruise #1 is maroon in color, linear and approx 2 cm x 1 cm. Bruise #2 is round, light purple 2 cm x 2 cm." The note also showed the resident had superficial scratches to both arms which the resident stated were from self harm. There was also a superficial

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wound to the resident's forehead that "appears to be an old wound that may have been opened up..."

f. Further review of the "Client Right Investigation Report" showed registered nurse (RN) #5 met the facility investigator on 3/7/23 at 10:30 AM to assess the resident #1. "There was a large blue, red and purple bruise and scrapes near the bruise on the mid to lower part of the ribcage area on the left side. When [RN] saw the bruise on [resident's] back she said "I didn't see that yesterday." [RN] asked [him/her] where he got the bruises and [resident] said from the staff-couldn't remember his name, beat [him/her] up...We asked [resident] if [s/he] could show me [his/her] left arm near the inner bicep and tricep area. There were several bruises, different sizes, all appeared to be recent as they were red, blue and purple with several scratches on inner arm area and on armpit and one on chest area, close to the armpit. I photographed all bruising and scratches/scrapes...[RN] said that the bruising on [his/her] back was from when [s/he] was throwing [himself/herself] around in the wheelchair, as it would match up that part of [his/her] chair and that [s/he] throws [himself/herself] really hard."

g. Interview on 3/31/23 at 8:48 AM with social worker #1 revealed he told security to use the suicide vest on the resident on 3/6/23 but he stated "there was miscommunication." He stated he did not mean for security to physically hold the resident in order to put it on. He stated the suicide vest should be a choice for the resident, and if the resident doesn't want to wear it, 1:1 staff can be utilized for safety.

h. During an interview on 3/31/23 at 9:58 AM security guard #2 stated they were told to put the suicide vest on the resident. He stated the resident was hitting them, and so they used a 2

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person body hug while the resident was in bed in order to get the vest on him/her. He stated the 2 person body hug was a MANDT [behavioral crisis intervention program] procedure in order to control the resident's arms so s/he couldn't hit. He stated it restricted the movement of the arms.

i. Interview on 3/31/23 at 9:13 AM with the resident #1 revealed s/he was put in bed and security staff and a CNA grabbed the "restraint vest" and put it on him/her. The resident stated s/he didn't want to wear it and staff held him/her down to put it on. The resident stated s/he has PTSD and "that added to it...nothing but nightmares since."

j. During interviews on 3/30/23 at 3 PM and on 3/31/23 at 10:56 AM the nursing home administrator (NHA) stated the suicide vest/smock was not a restraint because it was a velcro sleeveless smock that allowed freedom of movement and access to the body. However, the NHA acknowledged that security staff used MANDT procedures to hold the resident in order to put the vest on. She stated the facility did not consider MANDT procedures restraints and therefore the MDS assessment was not coded for restraints and the facility did not get orders for emergency use of MANDT holds. She further stated that she agreed that documentation related to MANDT holds needed to be better, and did not show how long the MANDT procedure was used or that the MANDT hold was released as soon as possible.

k. Review of "The Mandt System. Student Workbook, curriculum 2.0" (undated) provided by the facility showed the techniques/holds, including the side body hold, were identified as restraints. The Glossary of Terms included "...Physical restraint- The application of sanctioned physical techniques by one of more certified individuals

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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 604	Continued From page 10	F 604		

that reduces or restricts the ability of an individual to move their arms, legs, or head freely."

l. On 3/31/23 at 11:50 AM the facility administrator stated MANDT holds were considered restraints.

m. Review of the medical record for resident #1 showed no documentation related to the MANDT hold on 3/6/23, such as alternatives tried or how long the resident was restrained. Review of physician orders showed no order for the emergency use of a restraint on 3/6/23.

n. Review of the facility's policy "Use of Physical Restraints" (dated 4/1/22) showed "...Emergency use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment, and no other less-restrictive interventions are feasible. a. The Director of Nursing Services has the authority to order the use of emergency restraints. The Medical Provider must be notified of such use and the reason for the order. b. Orders for emergency restraints may be received by telephone and shall be signed by the physician within forty-eight (48)hours...Documentation regarding the use of restraints shall include:...c. How the restraint use benefits the resident by addressing the medical symptom; d. The type of physical restraint used; e. The length of effectiveness of the restraint time; and f. Observation, range of motion and repositioning flow sheets."