STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATION AND WELLNESS	**1002 FOREST DRIVE RIVERTON, WY 82501**

(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 7/19/2023 through 7/26/2023. The survey was prompted by complaint intakes WY00003627, WY00003633, and WY00003634.	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 observation, staff interview, medical record review, and policy review, the facility failed to protect the residents' right to be free from physical abuse by staff and by a resident for 2 of 6 sample residents (#4, #8). This failure resulted in harm to resident #4 and to resident #8, who showed evidence of psychosocial harm such as crying and shaking. The findings were: 1. Review of the admission record showed resident #4 was initially admitted to the facility on 5/11/22. The resident had a brief interview for	F 600	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation,	8/19/23

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

Electronically Signed | 08/18/2023

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F 600	Continued From page 1 mental status (BIMS) score of 0 out of 15, indicating the resident was severely cognitively impaired. Review of the resident's 7/20/23 diagnosis report showed the resident's diagnoses included chronic dementia with other behavioral disturbance, other specified depressive episodes, unsteady on feet, abnormalities of gait and mobility, lack of coordination, and abnormal posture. The following concerns were identified: a. Review of the nurse progress note dated 7/2/23 at 7:30 PM showed "Resident was slapped on the face today. Resident tearful after although is doing better and does not remember incident." b. Interview on 7/20/23 at 1:00 PM with hospitality aide (HA) #1 revealed she witnessed the 7/2/23 incident. The HA stated "[CNA #1] slapped [the resident] on the left side of [his/her] face while changing/toileting [him/her]. After [CNA #1] hit the resident [the resident] cried for about 15 minutes." The HA also stated that after the incident, the nurse was called, and the administrator, the police and family were notified. c. Telephone interview with CNA #1 on 7/20/23 at 5:50 PM revealed the incident occurred early in in the morning on 7/2/23, before the medication pass. The CNA described how the resident was refusing "to help" with cares, was grabbing onto the bathroom bar by the toilet, spitting, swinging his/her arms, pulling on his/her clothes, and refusing to sit on toilet. The CNA #1 stated that while providing care to the resident, she controlled the resident's arms and movements while trying to toilet him/her and change the resident's undergarments and clothes. The resident hit her multiple times and the CNA #1 slapped the resident's face. The CNA further stated, "...I know it was wrong of me but I reported it right away, I knew I was in trouble. They got rid of me."	F 600	this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. F600 Corrective Action Resident #4 has no memory of incident described in the 2567 and feels safe in the Center. Identified staff member was terminated from employment before working again after the incident. Resident #8 has returned to psychosocial baseline per progress notes and feels safe in the Center. Resident #8 was moved off the secure unit as to not be visually reminded of identified male resident's presence. Identification of Others Initial random audits completed via ECR, (EmpRes Care Rounds) and Safe Surveys, to assess for other residents who may have experienced or are fearful of an abuse situation. Resident # 3 was immediately placed on 1:1 monitoring. MD made aware with a medication review completed including medication adjustments. Because of a positive change in demeanor and the fact that Resident #3 spends much of his time in his private room, with IDT and MD consultation, a change from 1:1 monitoring to closely monitored while out of his room was initiated with good results. Systemic Changes Abuse observation, intervention, and timely reporting education has been	

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F 600	Continued From page 2 2. Review of the admission record showed resident #8 was initially admitted to the facility on 3/12/22. The resident had a BIMS score of 3 out of 15, indicating the resident was severely cognitively impaired. The resident had diagnoses listed which included fracture of other parts of pelvis, hypoxemia, mild cognitive impairment, need for assistance with personal care, dementia with other behavioral disturbance, abnormalities of gait and mobility. Review of the resident's care plan updated 6/9/23 showed the resident needed extensive assistance with activities of daily living. The following concerns were identified: a. Review of the progress note for resident #3 dated 7/1/23 at 3:22 PM showed "I was called to the Unit and saw [resident #8] on the floor crying. The CNA then reported that [resident #3] just threw a cup of fluids then [s/he] got out of [his/her] recliner went over to [resident #8], whom was approx. 10 feet away on the other side of a table, and grabbed [resident #8] by [his/her] hair pulling [his/her] head back and forth several times then pulled [resident #8] out of [his/her] chair onto the floor. This resident then went directly to [his/her] room and shut the door. The administrator was notified she attempted to notify the MD and families, messages left. 1 on 1 was started." c. Review of the facility incident report form dated 7/1/23 at 11:50 AM showed after the altercation resident #8 was visibly shaking, crying, and difficult to console. The resident stated "Why would a [man/woman] hurt a [man/woman] like that." Further review showed the resident was escorted to his/her room and assessed for injury. No injury was noted at that time. d. Interview with the facility administrator 7/20/23 at 11:05 AM confirmed an assessment	F 600	provided to current staff. Ongoing audits are being completed for 5 staff members per day, three days per week for at least three months to assess their abuse knowledge. Ongoing audits will be completed by ECR staff members for 5 residents per day, three days per week for at least three months to assess for residents with abuse concerns. Monitoring for Compliance Results of initial and ongoing audits will be reviewed via the QAPI process monthly times at least three months for further recommendations.	

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F 600	Continued From page 3	F 600		

was completed following the incident, no injuries were identified, and the physician and resident daughter were notified.

e. Interview with CNA #1 on 8/1/2023 at 1:42 PM confirmed she witnessed the incident and confirmed the events as described in the 7/1/23 at 3:22 PM progress note. The CNA stated resident #8 was pulled from the wheelchair onto the floor and was screaming and crying as a result of the incident. The CNA stated the altercation happened in less than 2 minutes and there was no time to anticipate or react to prevent it.

3. Review of the facility's policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated October 2022, showed: "Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse...In some abuse or neglect situations, it may be difficult to determine the psychosocial outcome to the resident. In these situations, it is appropriate to consider how a reasonable person in the resident's position would be impacted by the incident."