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 08/15/2023

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 8/14/23 through 8/15/23. The survey was prompted by complaint intake WY00003650. The following abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CVA: Cerebrovascular Accident IDT: Interdisciplinary Team MDS: Minimum Data Set TBI: Traumatic Brain Injury 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:	F 600	It is the policy of Mountain View Skilled Nursing Community (MVSNC) to ensure that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. MVSNC will provide a safe resident environment and protect residents from abuse. **CORRECTIVE ACTIONS** 1) Staff have increased supervision in the kitchen area when both residents are in the vicinity. The care plan for Resident #3 and #4 was reviewed and changed to specifically address potential for physical aggression as well as immediate action to be taken to prevent resident to resident altercation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine Szymanski | TITLE: SNF Administrator | (X6) DATE: 9/14/2023

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 Based on review of medical records, staff interview, review of facility investigations and incident reports, and review of policy and procedures, the facility failed to protect the resident's right to be free from physical and mental abuse by a resident for 1 of 4 residents (#3) reviewed for abuse. This failure resulted in harm to resident #3, who sustained bruising and expressed continued fear of resident #4. The findings were: Review of the quarterly MDS assessment dated 6/13/23 for resident #4 showed the resident had diagnoses which included CVA, non-Alzheimer's dementia, seizure disorder, TBI, and psychotic disorder. Further review showed the resident had a BIMS score of 13/15, indicating intact cognition. Review of the resident's reported behavior showed behavioral symptoms of hitting, kicking, pushing, scratching, grabbing, threatening others and screaming and cursing at others occurred 1 to 3 days every week. Review of the annual MDS assessment dated 5/31/23 for resident #3 showed the resident had diagnoses which included renal insufficiency, osteoporosis, a history of fractures, and non-Alzheimer's dementia. Further review showed the resident had a BIMS score of 7/15 indicating severe cognitive impairment. Review of the resident's behavior documentation included delusions along with weekly physical and verbal behaviors directed at others. The following concerns were identified: 1. Review of the facility investigation of a 7/23/23 at 10:20 PM incident between resident #4 and resident #3 showed resident #4 was in the bath and resident #3 was in the kitchen eating.	F 600	2) Other resident care plans were reviewed to determine if they were at risk of increased irritation with or from other residents and updated accordingly. Training has been conducted for direct care staff on the new interventions in the resident care plans to address monitoring of increasing irritation with other residents and decreasing altercations with other residents. 3) To assure sustainability going forward, direct care staff will be trained by nursing staff and/or Social Worker during weekly team meetings on the appropriate interventions to ensure resident safety, for the first month. Training sessions will specifically address assessing for recent factors or "red flags" regarding potential problematic aggression. Thereafter, they will receive this training by nursing and/or Social Services staff monthly x 2. 4) A summary of training and the review of resident care plans to address altercations/aggression, will be presented at the QAPI Committee. The Committees' recommendations will be followed if it is determined that reviews are no longer needed, or if they need to be extended. **RESPONSIBILITY/MONITORING** The Social Worker is responsible for compliance.	10/06/2023

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F 600	Continued From page 2	F 600		

Resident #4 came out of the bath and instead of going around the kitchen to get back to [her/his] room, [s/he] went through the kitchen, demanding resident #3 "move [her/his] fat ass" out of the way. When resident #3 did not move out of the way fast enough resident #4 made a fist and hit resident #3 on the shoulder and forearm. CNA #1 intervened and resident #4 attacked her making several contact punches to her chest. Resident #4 continued to chase and threaten staff members. As the incident progressed resident #4 yelled, regarding resident #3, that if [s/he] caught resident #3 [s/he] would "f**king kill" [him/her] and hoped [s/he] would "die and rot in hell."

2. Review of photographs taken at the time of the incident showed the left arm of resident #3 had several red marks. During the assessment resident #3 stated to the nurse s/he was "scared and shooken [sic] up."

3. Review of the facility's 7/24/23 incident report related to this incident showed the facility identified "reddish-purple bruises on [resident #3's] forearm which appeared to be the markings from knuckles where [resident #4] hit [him/her.]"

4. Interview with resident #3 on 8/15/23 at 10:15 AM revealed "I avoid [resident #4]. [S/He] scares me."

5. Interview conducted with CNA #2 and CNA #3 on 8/15/23 at 10:30 AM revealed care provided for resident #4 was in flux from day to day, and [his/her] response to the methods used to intervene with aggressive behavior varied.

6. Interview with the facility human rights advocate/investigator on 8/15/23 at 11 AM

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F 600	Continued From page 3 revealed she had received statements from all of the staff who witnessed the occurrence and determined the incident did constitute abuse as defined. 7. Review of the policy and procedure titled "Prevention of Resident Abuse, Neglect, and Exploitation" dated 6/20/22 showed "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined ...It is the policy and practice of the Wyoming Life, Resource Center (WLRC) that all residents will be protected from abuse and neglect. WLRC will not tolerate any form of resident abuse and will continually monitor WLRC policies, procedures, training programs, etc., to assist in preventing resident abuse."	F 600		