| 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 10/10/2023 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys from 10/9/23 through 10/10/23. The survey was prompted by complaint intake WY00003683. | F 000 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff and resident interviews, and review of incident reports and facility documentation, the facility failed to protect the resident's right to be free from physical abuse by a client from another facility for 1 of 1 sample residents (#1) reviewed for abuse allegations, which resulted in physical and psychosocial harm. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 10/6/23. The findings were:<br><br>1. Review of the 9/12/23 significant change | F 600 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine Szymanski | TITLE: SNF Administrator | (X6) DATE: 11/02/2023

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<br>Minimum Data Set (MDS) assessment showed resident #1 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact.<br><br>2. Review of a progress note dated 9/19/23 showed the resident attended work for a little while, but then came home due to an altercation.<br><br>3. Review of an incident report submitted to Healthcare Licensing and Surveys (HLS) showed on 9/19/23 a client (#C1) from another facility (located on the same campus) attacked resident #1 at the resident's work station. It was documented the resident received a scratch near his/her armpit and a torn shirt.<br><br>4. On 10/9/23 at 3:19 PM security officer #1 stated on 9/19/23 while on foot patrol he encountered client #CI, who was upset at resident #1 for something s/he had said. The security guard went to the training center where resident #1 was working and asked him/her to apologize to client #C1. He stated he was observing from around the corner when client #C1 entered the training center and went over to resident #1. He stated resident #1 started to apologize to client #C1 when client #C1 grabbed the resident by the shirt, and tore his/her shirt. The security guard separated the residents and other staff arrived to help.<br><br>5. During an interview on 10/9/23 at 3:30 PM security guard #2 stated when her arrived to the training center on 9/19/23 he saw security guard #1 had ahold of client #C1, who was trying to get to resident #1. He stated resident #1 was in his/her wheelchair and was not fighting back. | F 600 | | |

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| F 600 | Continued From page 2<br>6. On 10/9/23 at 3:45 PM shift supervisor #1 stated he was attending a training at the training center on 9/19/23 and during a break he came around the corner and heard resident #1 stating s/he wouldn't apologize to client #C1, and client #C1 was ripping the shirt off of resident #1. He stated security was present.<br><br>7. During an interview on 10/9/23 at 4:27 PM resident #1 stated on 9/19/23 s/he encountered client #C1 outside who yelled at him/her. Resident #1 stated s/he ignored it and went to work at the training center. S/he stated security guard #1 came to him/her and asked if s/he could apologize to client #C1 and s/he said OK. Resident #1 stated client #C1 came in and started yelling. Resident #1 stated s/he said "sorry" and then client #C1 grabbed his/her hand and slammed it on the desk. S/he stated the client then grabbed him/her and ripped their shirt. The resident stated s/he received a scratch near his/her shoulder and forearm. The resident stated as a result of the altercation, s/he was "afraid" of client #C1. The resident stated "I hate to be scared, but I am."<br><br>8. On 10/10/23 at 8:30 AM Professional Development Center (PDC) instructor #1 stated on 9/19/23 she didn't observed the actual incident between client #C1 and resident #1 because security had already intervened when she came upon it. She stated that she did talk to resident #1 after the incident. She stated resident #1 was "visibly shaken" with a trembling voice. She stated resident #1 had a ripped shirt.<br><br>9. During an interview on 10/10/23 at 9 AM resident rights advocate #1 stated client #C1 attacked resident #1 on 9/19/23. She stated the | F 600 | | |

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| F 600 | Continued From page 3 | F 600 | | |

resident had a ripped shirt and a small scratch. She stated she would consider the incident substantiated for abuse because the client did get ahold of the resident and ripped his/her shirt.

10. During an interview on 10/10/23 at 11:06 AM registered nurse (RN) #1 stated she assessed resident #1 after the incident. She stated the resident had a little scratch that s/he claimed was from client #C1. She stated it could have been because the resident did have a ripped shirt. She stated since the incident the resident has said s/he is afraid of client #C1.

11. Review of a progress note dated 9/19/23 by RN #1 showed "Upon assessment, [resident] had no redness or bruising noted to shoulders although [s/he] was claiming [his/her] pain was a "9 and now was a 12". Did have a small scratch to right inner shoulder. Left forearm where [resident] had a scab was also opened now but unknown if that was from other resident or [resident] picked at it as [s/he] is known to pick at [his/her] skin ...although [resident] reports that other resident did that as well..."

12. Review of facility documentation and interview with the nursing home administrator on 10/10/23 at 1:24 PM revealed the facility already had a plan of correction for F600 in place prior to this incident, and it continued after the incident. Compliance was determined to be met on 10/6/23. The actions taken by the facility included:

a. The client from the other facility (#C1) had his/her work route changed so s/he would not be in the same building as resident #1.

b. All residents have had their care plans updated to reflect risk of abuse.

c. Staff education related to abuse, with focus

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| F 600 | Continued From page 4<br>on resident to resident abuse, was completed on 9/19/23, 9/26/23, and 10/3/23. Additional trainings are scheduled. Trainings were scheduled weekly for one month then monthly for two months.<br>d. Audits were completed related to abuse and monitored in quality assessment and performance improvement (QAPI) meetings. Audits are continuing.<br><br>There have been no other allegations of abuse since this incident. | F 600 | | |