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 09/05/2024

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 9/3/24 through 9/5/24. The survey was prompted by complaint intakes WY00003959, WY00003944, and WY00003920. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant RN: Registered Nurse DON: Director of Nursing Less commonly used abbreviation 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, resident representative and staff interview, and policy and	F 600	F600 The facility will ensure that residents will be free from abuse and	10/31/24

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

Electronically Signed | 09/26/2024

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F 600	Continued From page 1 procedure review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 2 sample residents (#1 and #2) reviewed for allegations of abuse. The findings were: 1. Review of an incident report dated 7/30/24 showed resident #2 assaulted his/her roommate, resident #1, with the metal clip of a pair of suspenders. Further review showed the clip caused a 1centimeter (cm) laceration to resident #1's left cheek and the resident required treatment in the emergency room (ER). The following concerns were identified: a. Review of medical record dated 7/31/24 showed resident #1 was transferred to the ER and received treatment of the wound with steristrips. Bruising also developed at the site of the wound. b. Interview with CNA #6 on 9/4/24 at 5:30 PM confirmed CNA #6 had assisted resident #1 to the restroom and walked resident #1 into the bedroom when resident #2 ran across the room, jumped up and swung suspenders at resident #1, hitting resident #1 in the face. CNA #6 revealed resident #2 continued to swing at resident #1 and he had to hold resident #2 back to prevent further assault. c. Interview with RN #2 on 9/4/24 at 5:58 PM revealed CNA #6 had to keep resident #2 back from resident #1 after resident #2 hit resident #1 in the face with the buckle of his/her suspenders. RN #2 reported resident #1 was in "shock" after the incident and was sent to the ER for evaluation and treatment. 2. Interview with the resident representative for resident #1 on 9/4/24 at 1:41 PM revealed s/he questioned why staff had put a roommate in with	F 600	neglect. Resident #2 did not exhibit any further aggression toward resident #1 or any other residents after the incident. Resident #1 was moved to another room at the request of his POA. Resident #1 did not show any changes in behavior or his routine. He adjusted well to the new room and his new roommate. Resident #2 was monitored by staff for his location. His suspenders and belt were removed from his possession, and any other items that he may injure himself or others Resident #2 was put on 1:1 activities. He was not receptive to the 1:1 activities, and refused to participate any group activities. He began to refuse to come out to meals. Resident began to physically and cognitively decline. He began to refuse to get out of bed or leave his room. Staff checked him on throughout their shifts and offered nutrition, hydration, repositioning and 1:1 interaction. Family was notified of his condition did not want any life sustaining interventions or diagnostic interventions for resident per their wished at time of admission Resident #2 passed away 9/10/2024. During his decline, he refused to leave his room. There was no further interaction between this resident or any other resident. 1) Education has been provided to staff regarding re-direction of upset or agitated residents while protecting the rights of both residents. Education has been provided via video and written	

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F 600	Continued From page 2 resident #1 due to the resident's blindness, deafness and inability to communicate. The resident representative reported resident #1 "never saw it coming." 3. Interview with the DON on 9/4/24 at 2:55 PM revealed she was working on a different system for reporting incidents and investigations which will include having a paper copy and witness statements. She revealed there is not a performance improvement plan (PIP) in place and staff have monitored resident #2 to figure out how to manage behaviors, though there is no documentation on that. 4. Review of the policy titled "Abuse and Neglect - Clinical Protocol & Guidelines" last reviewed 8/2016 showed "...a. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."	F 600	communication. a. Emphasis is placed de-escalation before there is any physical escalation or abuse of another person. 2) Residents with a history of behaviors or aggression will be care planned with non-pharmacological interventions. Meaningful activities will be implemented that will have the goal of enhancing the resident's lives. Meaningful activities will be implemented by 10/15/2024 and monitoring of at risk residents participating in activities will be monitored until 1/15/2025 and ongoing. This process will be reviewed at QAPI monthly through 1/15/2024 and ongoing. 3) The DON has developed a safety contract and they will be completed with family and the resident to help avoid escalation of behaviors that may become directed at other residents. The safety contract will be made available to staff and reviewed with them when changes are made. Safety Contracts will be completed for at risk residents by 10/15/2025 and behavior monitoring, and chart reviews will be completed through 1/15/2025 and ongoing. The activity program for Dementia residents and residents with behaviors will be reviewed at monthly QAPI and weekly at LTC IDT through 1/15/2025 and ongoing.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		10/31/24

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F 744	Continued From page 3 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to develop and implement interventions to address the residents' dementia care needs for 1 of 2 sample residents (#2) reviewed for dementia treatment and services. The findings were: 1. Review of the admission Minimun Data Set (MDS) dated 7/31/24 showed resident #2 had moderately impaired cognitive skills, inattention/disorganized thinking behavior present, inability to recall staff names/faces, inability to recall s/he lived in a nursing home, and a mood interview score of 21, indicating severe depression. The following concerns were identified: a. Review of progress note dated 7/23/24 showed resident #2 arrived in the facility and verbally expressed his/her displeasure at his/her arrival. Resident #2 was disheveled, ungroomed and wore unclean clothing. Resident #2's family stated it had been 2 weeks since they were able to get him/her to shower, and reported s/he was becoming more incontinent and refused to wear incontinence products. Resident #2 refused to eat meals and ate only ice cream bars and banana bread. b. Review of a progress note dated 7/24/24 showed resident #2 paced up and down the hall looking for his/her family, went in and out of rooms and needed redirecting and explanations repeated multiple times.	F 744	F744 The facility will provide serves and treatment for residents with Dementia and behaviors. 1) Crook County Medical Center LTC is working with Chronic Care Management to provide Behavioral Health Integration (BHI). This program bridges the gap between mental health and physical care. Their staff and ours work closely with patients and their primary care providers to address both medical and behavioral health needs. This includes screening for mental health conditions, coordinating therapy or counseling, and ensuring mental wellness is part of the patient’s overall treatment plan. The DON or designee will work with the Chronic Care Manager to provide care for residents that are in need. The DON or designee will do auditing and assessment of residents for effectiveness of involvement in this program by auditing charts for behavior changes during week days through 1/15/2025 and ongoing. The process will be reviewed monthly at LTC QAPI and weekly at LTC IDT. This will also be accomplished through observation of resident interactions with others and interviews with staff about how effectively resident’s plan of care is working for them.	

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F 744	Continued From page 4 c. Review of a progress note dated 7/25/24 showed resident #2 had his/her prescription of Seroquel increased on 7/24/24. S/he had been awake most of the night, and shown where his/her bathroom was multiple times. S/he had been in and out of other's rooms, was difficult to remove at times, and argued "I'll go anywhere I damn well please" and "I don't care whose room it is." While in other resident's rooms s/he yelled and swore, and raised his/her fists multiple times when CNAs removed him/her from the rooms. d. Review of a progress note dated 7/25/24 showed resident #2 cursed the staff for 1.5 hours, accused staff of holding him/her hostage, followed the staff, and tried to open the doors, setting off alarms. S/he asked for water and then accused staff of "doping it up." Staff offered food and tried to visit with the resident. e. Review of a progress note dated 7/30/24 showed Resident #2 assaulted his/her roommate with the metal clip of a pair of suspenders, and caused a 1 cm laceration to resident #2's left cheek. 2. Interview with the DON on 9/4/24 at 2:55 PM revealed staff have monitored resident #2 to figure out how to manage his/her behaviors, though there was no documentation on that. 3. Interview with the DON on 9/4/24 at 4:07 PM revealed there was no facility policy on behavior management or dementia care, and the DON planned to create these policies. 4. Interview with the DON on 9/5/24 at 9:54 AM revealed there had been no education given to staff on dementia care for the past two years. It had been planned for last month but was postponed due to area fires and the the bike rally.	F 744	1) Staff will be educated on the dementia policies that have now been implemented. The following policies are, Dementia Care – Grief, ADL Care of Dementia Unit Residents, and Dementia Care. 2) Long term care has implemented a weekly IDT meeting at which each resident is reviewed for changes to behaviors or any concerns that need addressing, are discussed and a plan is implemented. 3) The DON or designee will do daily chart audits, during the weekdays, monitoring for any change in resident behaviors. Audits daily during week days until 1/15/2025 and ongoing. 4) Residents with a dementia diagnosis will have a behavior charting TAR added. 5) All long term care staff will have annual training on care of residents with dementia and behaviors. This training will include review of The Abuse, Neglect and Exploitation Policy. 6) Education will include use of non-pharmacological interventions. The DON or designee will work with family and the resident to identify such interventions and create a safety contract. The contract will be shared with the with staff. Contracts will be updated in resident care plan. 7) All staff will be trained on dementia and dementia care practices upon hire, annually and as needed. 8) All incidents will continue to be investigated and reported as appropriate. Incident reporting will be done via Yellowstone Incident Reporting System per facility protocol.	

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F 744	Continued From page 5 The DON revealed the training was rescheduled for the upcoming all-staff meeting.	F 744	9) The DON or designee will audit staff training, policy review and reporting monthly and bring to QAPI for 6 months or until the QAPI committee feels this process has been appropriately resolved.	