STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	**1108 BIRCH STREET DOUGLAS, WY 82633**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 1/3/25 which was prompted by complaint intakes WY00004113 and WY00004114. The following common abbreviations are used throughout this document: MDS: Minimum Data Sheet Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled	F 567		2/14/25

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

Electronically Signed | 02/25/2025

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F 567	Continued From page 1 accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on review of resident trust fund account statements, staff interview, and Medicaid eligibility review, the facility failed to ensure residents' right to manage their personal funds for 2 of 13 (#1, #2) sample residents with accounts at the facility. The findings were: 1. Review of the resident trust fund account statement for resident #1, with a start date of 11/15/22 showed the resident had a balance of $50.02 in the account on 4/30/24. The following concerns were identified: a. On 5/3/24 the facility received a payment of $1,267.00 from the Social Security Administration (SSA) which was deposited into the resident's account. On 5/7/24 a payment was made to the facility for $1,317.02 which left a zero balance in the resident's account. There was no evidence the resident had received his/her $50 personal needs allowance. b. On 6/3/24 the facility received a payment	F 567	F 567 Protection/Management of Personal Funds 1: The facility will ensure residents rights are not infringed upon to manage their personal funds. 2: Residents #7 (KM) will have a total of $250 reimbursed to them for the months of 5/24,6/24,8/24,10/24 and 11/24. 3: Resident #1 (RH) will have a total of $ 375 reimbursed to them for the months of May 2024-December 2024. 4: All residents who have their personal funds managed by Douglas Care Center (DCC) have the potential to be affected by this deficient practice. 5: Any staff that manages residents' personal funds and on Medicaid will be educated that if they are not current on their bill that the $50 for personal needs can not be used to help payback balance unless permission is given; education will	

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F 567	Continued From page 2 of $1,267.00 from the SSA which was deposited into the resident's account. On 6/3/24 a payment was made to the facility for $1,270.70 which left a balance of minus $.70 in the resident's account. There was no evidence the resident had received his/her $50 personal needs allowance. c. On 8/1/24 the facility received a payment of $1,267.00 from the SSA which was deposited into the resident's account giving the resident a balance of $1,316.60. On 8/7/24 a payment was made to the facility for $1,316.60 which gave the resident a zero balance in his/her account. There was no evidence the resident had received his/her $50 personal needs allowance. d. On 9/3/24 the balance in the resident's account was $50.00 with an interest payment of $.02 deposited on 9/30/24. On 10/3/24 the facility received a payment of $1,267.00 from the SSA which was deposited into the resident's account giving the resident a balance of $1,317.02. On 10/3/24 a payment was made to the facility for $1,267.02. There was no evidence the resident had received his/her $50 personal needs allowance as the resident's balance remained at $50.00. e. On 10/31/24 an interest payment of $.03 was deposited into the resident's account. On 11/1/24 the facility received a payment of $1,267.00 from the SSA which was deposited into the resident's account giving the resident a balance of $1,317.03. On 11/4/24 a payment was made to the facility for $1,317.03 which gave the resident a zero balance. There was no evidence the resident had received his/her $50 personal needs allowance. 2. Review of the resident trust fund account for resident #2, with a start date of 7/11/22, showed the resident had a balance of $51.37 on 4/30/24.	F 567	be done by NHA or designee. 6: An audit of all residents who are on Medicaid and DCC manages their funds will be done to ensure that they receive their $50 for personal allowance. 7: The results of the audit will be brought to QAPI for 90 days or until resolved.	

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F 567	Continued From page 3	F 567		

The following concerns were identified:

a. On 5/1/24 the facility received a payment of $2051.00 from the SSA which was deposited into the resident's account. On 5/7/24 a payment was made to the facility for $2,077.37 leaving the resident a balance of $25.00. There was no evidence the resident had received his/her $50 personal needs allowance.

b. On 5/28/24 the facility received a payment of $2,051.00 from the SSA which was deposited into the resident's account. On 5/28/24 a payment was made to the facility for $2,051.00. There was no evidence the resident had received his/her $50 personal needs allowance.

c. On 6/25/24 the facility received a payment of $2,051.00 from the SSA which was deposited into the resident's account. On 6/25/24 a payment was made to the facility for $2,076.00 which left the resident with a zero balance. There was no evidence the resident had received his/her $50 personal needs allowance.

d. The resident was discharged from the facility on 7/17/24 with a return not anticipated; however, the facility received monthly payments from the SSA on 8/7, 9/3, 10/8, 11/4, and 12/2 which totaled $8,904.00. A payment to the facility was made after each of these deposits leaving the resident a zero balance on 12/2/24.

3. Interview with the former administrator on 1/3/25 at 9:50 AM revealed both residents owed the facility a large amount of money and was using the resident's personal funds allowance to pay down the balance.

4. Review of the Wyoming Medicaid Long Term Care Programs, Benefits & Eligibility Requirements retrieved from https://www.medicaidlongtermcare.org/eligibility/w

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F 567	Continued From page 4 yoming/ on 1/6/25 showed "Wyoming Nursing Home Medicaid beneficiaries are required to give most of their income to the state to help cover care expenses. They are only allowed to keep a "personal needs allowance" of $50/month, which can be spent on personal items such as clothes, snacks, books, haircuts, flowers, etc."	F 567		
F 600 SS=D	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 staff interview, medical record review, facility incident investigation review, facility performance improvement plan review, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 5 (#3) residents involved in a resident-to-resident altercations. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 12/20/24. The findings were:	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 5	F 600		

1. Review of the 10/16/24 quarterly MDS assessment for resident #3 showed the resident had short-term and long-term memory problems and diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and dementia. The resident did not exhibit any behaviors, rejection of care, or wandering during the look-back period. The following concerns were identified:

a. Review of a 12/9/24 and timed 9:57 PM progress note showed the resident was sitting at a table in the dining area when a resident (identified as resident #4) walked over to the resident and struck him/her on the left side of his/her face. The staff had their backs to the resident and were alerted to the altercation due to the resident calling out after the strike. The resident was assessed with no immediate injury noted and neurological assessments were initiated due to the location of the impact. Further, the progress note stated the surveillance footage was observed and confirmed the incident.

b. Interview with helping hand #1 on 1/3/25 at 9:15 AM revealed she was sitting with resident #4 doing a puzzle when she was called away to replace an absorbent pad in one of the recliners. Both she and the nurse had their backs to the resident when resident #3 yelled "ouch" which alerted them to the incident. The helping hand stated resident #4 went back to the puzzle table after the incident; however, s/he appeared to be agitated. The helping hand confirmed she had stayed with the resident until the resident had gone to bed.

c. Review of the facility's incident report showed resident #3 "was very distraught and holding the side of [his/her] face where [resident #4] smacked [him/her]" The initial assessment showed no injury; however, the next day the

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F 600	Continued From page 6	F 600		

resident had "a little bit of a bruise" on his/her face. Further review of the incident report showed "Camera footage showed [resident #4] was calm and working on a puzzle. [Resident #3] was sitting at the table minding [his/her] own business. After watching the video footage of incident, it was verified that [resident #4] was unprovoked. [Resident #4] intentionally walked over to [resident #3] and smacked [him/her] in the side of the face. Afterwards [resident #4] walked back over to [his/her] puzzle."

d. Review of the progress notes for resident #4 showed the resident had incidents of verbal and physical aggression to both staff and residents on 11/22, 11/24, 11/26, 11/27, 11/30, 12/1, 12/7, 12/9, and 12/11.

e. Interview with the administrator on 1/3/25 at 9:25 AM revealed after the incident on 12/9/24 the facility increased staffing to ensure 3 staff members were in the secure unit at all times, with sometimes 4 during the evening hours. In addition, if resident #4 was agitated the department heads would be called to assist. Further the facility stopped the extra traffic through the secure unit, scheduled a psychological evaluation for the resident, and medication changes had been prescribed for the him/her. Interventions to deescalate the resident were defined and documented in the resident's care plan and progress notes.

f. Review of a 12/12/24 social services note showed the family of resident #4 was notified the facility was unable to meet the residents needs and referrals to other long-term care facilities, which could better meet the resident's needs, were going to be made.

g. Interview with the social services director on 1/3/25 at 9:11 AM revealed resident #4 had been accepted at another long-term care facility

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F 600	Continued From page 7	F 600		

and had been scheduled to be transferred on 1/6/25.

h. Review of resident #4's progress notes showed the resident had experienced a sharp decline in condition and expired on 1/2/25.

2. Review of the "Abuse, Neglect, and Exploitation" policy, implemented on 5/30/23, showed "...Prevention of Abuse, Neglect and Exploitation...B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms;...The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect...Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur..."

3. Review of the facility's 11/18/24 performance improvement plan of correction showed the key areas for improvement included behavioral health documentation, behavioral health implementation, physician involvement, and staff education. The goals were to ensure behavioral documentation and follow-ups were completed; 100% of behavioral interactions were documented, care planned, and follow-up appointments were made, if needed; and to organize an incident review committee that meets weekly. The root causes of the problem were determined to be the amount of

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F 600	Continued From page 8 traffic in the unit; the residents were not busy enough, lack of staff education on behavioral health in the elderly, lack of documentation when behaviors happened, and lack of communication between the nursing staff and physicians. Further review showed the plan was implemented on 12/9/24. The facility was determined to be in substantial compliance as of 12/20/24.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		2/14/25

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F 609	Continued From page 9 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on the facility's abuse investigation forms, State Survey Agency incident database review, policy and procedure review, and staff interview, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of the reasonable suspicion of a crime in for 2 of 5 sample residents (#3, #7) reviewed for allegations of abuse. The findings were: 1. Review of the facility's policy "Abuse, Neglect, and Exploitation, implemented on 5/30/23, showed "...Reporting/Response...1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury..." The following concerns were identified: a. Review of the facility's "Resident Abuse Investigation Report Form" showed a resident-to-resident altercation occurred on 12/9/24 at 6:55 PM and was reported to facility administration at 7 PM; however, review of the state survey agency incident database showed this allegation was not reported to the agency until 12/12/24 at 12:28 PM. b. Review of the facility's "Resident Abuse Investigation Report Form" showed a resident-to-resident altercation occurred on 12/25/24 at 7:40 AM and was reported to facility administration at 7:44 AM; however, review of the state survey agency incident database showed this allegation was not reported to the agency until 12/25/24 at 12:46 PM.	F 609	F609 Reporting of alleged Violations. 1: The facility will ensure that they have developed and/or implement policies and procedures for ensuring the reporting of the reasonable suspicion of a crime. 2: All residents have the potential to be effective by this deficient practice. 3: On on-call schedule has been set up between the NHA, Social Service (SS), DON and Controller of who is responsible for reporting allegations on a weekly basis. 3: SS, DON, NHA and Controller will be educated on Douglas Care Center's (DCC) Abuse, Neglect, and Exploitation Policy; specifically, on ensuring that alleged allegations are reported within two hours of allegations; NHA or designee will conduct education 4: An audit of all allegations of Abuse, Neglect and Exploitation will be audited to ensure they were reported within two hours. 5: The results of the audit will be brought to QAPI for 90 days or until resolved.	

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F 609	Continued From page 10 2. Interview with the former administrator, the administrator, and the social service director on 1/3/25 at 11:09 AM confirmed the allegations of abuse were not reported within the required timeframe.	F 609		