

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Crook County Medical Services District Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 713 Oak Street Sundance, WY 82729	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>50485</p> <p>Based on medical record review, resident representative and staff interview, 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 2 sample residents (#1 and #2) reviewed for allegations of abuse. The findings were:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 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. <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	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.

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485</p> <p>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:</p> <ol style="list-style-type: none"> 1. Review of the admission Minimum Data Set (MDS) dated [DATE] 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: <ul style="list-style-type: none"> 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. 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. <p>(continued on next page)</p>

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The DON revealed the training was rescheduled for the upcoming all-staff meeting.		