

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 11/05/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35081</p> <p>Based on staff interview and state agency incident database review, the facility failed to ensure investigations for abuse allegations were reported within 5 working days for 1 of 1 sample residents (#3). The findings were:</p> <ol style="list-style-type: none"> 1. Review of the state survey agency incident database showed an allegation of staff to resident abuse was made by resident #3 to the facility charge nurse on 9/20/24. Further review showed the initial report was sent to the State Survey Agency on 9/23/24; however, there was no evidence the facility's investigative findings were reported as of 11/5/24. 2. Interview with the director of nursing on 11/5/24 at 5:17 PM confirmed the investigation had not been reported. Further interview revealed she did know she needed to report the investigation to the state survey agency.

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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