

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  535040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/03/2025
NAME OF PROVIDER OR SUPPLIER  Douglas Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1108 Birch Street Douglas, WY 82633	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>37220</p> <p>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:</p> <p>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:</p> <p>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.</p> <p>b. On 6/3/24 the facility received a payment 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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. The following concerns were identified:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>4. Review of the Wyoming Medicaid Long Term Care Programs, Benefits &amp; Eligibility Requirements retrieved from <a href="https://www.medicaidlongtermcare.org/eligibility/wyoming/">https://www.medicaidlongtermcare.org/eligibility/wyoming/</a> 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.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220</b></p> <p>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 [DATE]. The findings were:</p> <p>1. Review of the [DATE] 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:</p> <p>a. Review of a [DATE] 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.</p> <p>b. Interview with helping hand #1 on [DATE] 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.</p> <p>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 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.</p> <p>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 ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Interview with the administrator on [DATE] at 9:25 AM revealed after the incident on [DATE] 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.</p> <p>f. Review of a [DATE] 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.</p> <p>g. Interview with the social services director on [DATE] at 9:11 AM revealed resident #4 had been accepted at another long-term care facility and had been scheduled to be transferred on [DATE].</p> <p>h. Review of resident #4's progress notes showed the resident had experienced a sharp decline in condition and expired on [DATE].</p> <p>2. Review of the Abuse, Neglect, and Exploitation policy, implemented on [DATE], 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 .</p> <p>3. Review of the facility's [DATE] 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 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 [DATE]. The facility was determined to be in substantial compliance as of [DATE].</p>		

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<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>37220</p> <p>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:</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p>		