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	11/15/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on medical record review and staff interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 4 resident-initiated discharges (#97) reviewed. The findings were: Review of the 7/17/24 MDS discharge assessment for resident #97 showed s/he was admitted to the facility on [DATE] and was discharged to a short-term general hospital on 7/17/24 with a return to the facility not anticipated. Further review of the medical record showed no evidence a discharge summary had been completed. Interview on 11/14/24 at 5:15 PM with the NHA confirmed the discharge summary had not been completed.

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37220 Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure bed rails were evaluated for safety on a regular basis for 1 of 2 residents (#15) reviewed with bed rails. The findings were: 1. Observation on 11/12/24 at 1:15 PM showed resident #15 had an assist bar, bilaterally, at the head of the bed. Review of the resident's medical record showed the last assist bar evaluation was completed on 4/6/21. Interview with the MDS coordinator on 11/13/24 at 4:20 PM revealed safety assessments should be conducted annually and confirmed no further documentation was available. 2. Review of the 2/13/23 Use of Assistive Devices policy showed .2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care 4. DCC staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, safety evaluations, set up assistance, supervision, or physical assistance as needed .6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 Based on nursing staff schedule review and staff interview, the facility failed to have a system in place to document licensed nurses in the facility on a 24-hour basis. The findings were: 1. Review of the PBJ (payroll-based journal) Staffing Data Report for July 1 through [DATE] showed the following concerns: a. The PBJ showed the facility failed to provide nursing coverage 24 hours/day on 7/21, 7/23, and 7/30. b. Review of the working schedule showed on 7/21 the DON was on duty for 12 hours starting at 6 AM. On 9/10, 9/23, and 9/30 the DON was shown as working a 12-shift starting at 6 PM. The other days noted on the PBJ were covered by nursing staff. 2. Review of the PBJ Staffing Data Report for October 1 through December 31, 2023 showed the following concerns: a. The PBJ showed the facility failed to provide nursing coverage 24 hours/day on 10/1, 10/8, 10/29, 11/23, 12/2, 12/3, and 12/9. b. Review of the working schedule showed on 10/29 the DON worked a 12-hour shift starting at 6 AM. On 11/23 the DON worked 12 hours starting at 6 PM. In December the schedule showed the DON worked 12 hours started at 6 PM on 12/2. The other days noted on the PBJ were covered by nursing staff. 3. Interview with the NHA on 11/15/24 at 8:55 AM revealed she had only been doing the PBJ for couple of months. The former PBJ data entry person was no longer employed. Further, she stated the DON was salary, and was unable to clock in without causing problems with the payroll system. She stated there was no way of proving the DON had worked the floor, except showing it on the schedule. She stated the facility had recognized the problem and had added a performance improvement project to their quality assessment.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on observation, medical record review, and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 2 of 4 residents (#4, #97) reviewed for behavioral and emotional needs. This failure resulted in actual harm to resident #97. The findings were: 1. Review of the 7/17/24 MDS discharge assessment for resident #97 showed s/he was admitted to the facility on [DATE] and was discharged to a short-term general hospital on 7/17/24 with a return to the facility not anticipated. Review of the 4/23/24 quarterly MDS assessment showed the resident had diagnoses which included non-traumatic brain dysfunction and non-Alzheimer's dementia. Further review showed the resident had a staff assessment for mental status which indicated moderate cognitive impairment, disorganized thinking which fluctuated in severity, exhibited verbal behavioral symptoms directed towards others 1 to 3 days of the 7-day look-back period, behavioral symptoms not directed toward others 4 to 6 days of the 7-day look-back period, and rejected care 1 to 3 days of the 7-day look-back period. The resident was coded as receiving an antianxiety medication. Review of the 12/6/23 Office Physician Progress note showed a hearing was held last week before [judge's name] to determine the patient's need for a power of attorney, and to seek placement where [s/he] could get more effective care for [his/her] emotional disturbances and be less disruptive to other patients around. The progress note showed the resident had a diagnosis of aggressive behavior due to dementia. Review of a subsequent note showed the court determined the resident to be incompetent on 12/15/23. Review of a 2/28/24 physician's verbal order showed an order was placed for the resident to have a psychological evaluation. The verbal order was signed by the physician on 3/6/24. The following concerns were identified: a. Review of the resident's entire medical record showed no evidence a psychological evaluation had been completed. b. Review of the Event Reports from 3/3/24 to 6/29/24 showed the resident had aggressive/combative behaviors on 3/3, 3/18, 3/19, 3/22, 3/27, 4/3, 4/13, 5/8, 5/18, 6/13, 6/20, and 6/29. c. Review of the resident's care plan showed a description of resident-to-resident interactions which occurred on 1/31/24, 2/12/24, 2/14/24, 3/7/24, 3/18/24, 3/19/24, 3/22/24, 3/24/24, 6/13/24, 6/20/24, and 6/29/24; however, the only intervention noted was 3/14/24 which showed My staff will attempt to place a stop sign in my doorway to keep other residents from wandering into my room. The previous interventions related to resident-to-resident interactions or behaviors were dated on or before 8/29/23. d. Review of the resident's care plan under the category of Special treatments last edited on 4/24/24 showed I will break my furniture in my room. My bed is zip tied to itself so I can't bang it on the ground. I broke the door on my nightstand, so it has been removed for my safety. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	e. Review of the resident's care plan under the category of Call Light, dated 5/8/24 showed My call light cords were removed for my safety and the safety of others around me due to me trying to use call light cords as whips. Call light stoppers were placed where cords were. My staff will attempt to anticipate my needs. f. Review of a progress note dated 7/17/24 and timed 10:28 PM showed pt (patient) stuck (sic) a female resident in the lower back with the back of [his/her] hand while [s/he] was walking down the hall .female suffered no apparent injury, pt's behavior continued to escalate until two staff members had to barrackade (sic) themselves along with some of the patients in two different rooms to protect themselves and patients from pt's violent behavior, charge nurse called 911 for help, officers deesalated (sic) pt's aggitation [sic], guardian and [a mental health service] were called, a zoom mental health evaluation was performed on pt, emt's [sic] were called and pt was taken from facility, md notified. g. Review of a progress note dated 7/19/24 showed the resident's guardian had notified the facility that the judge had granted an official order to have the resident placed in the state hospital. h. Interview with the NHA on 11/14/24 at 4:12 PM revealed she had an email chain related to the scheduling of the resident for a psychological evaluation which showed that due to the rural location of the facility the evaluation was not scheduled; however, an appointment with a neurologist had been scheduled for 4/10/24. The NHA confirmed no documentation of the attempts to schedule the psychological evaluation or the neurologist's progress notes had been documented in the resident's medical record. 2. Review of the 9/13/24 quarterly MDS assessment showed resident #4 was readmitted from an acute care hospital to the facility on [DATE] and had diagnoses which included cerebrovascular accident, non-Alzheimer's dementia, depression and bipolar disorder. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident did not exhibit physical or verbal behavioral symptoms or rejection of care. Review of the resident's care plan, dated 3/22/23, showed, When I have suicidal ideations or similar behaviors my staff will try to redirect me, they may offer me to call my counselor that I see or my family. They may take me to the common area or dining room to visit and interact with people and so my staff can ensure my safety. Further review showed the resident received antipsychotic and antidepressant medications, and the last gradual dose reduction was clinically contraindicated by the physician on 2/21/24. The following concerns were identified: a. Review of a progress note dated 6/8/24 at 1:39 PM showed a CNA notified RN #1 of a note found on the resident's bedside table that stated I wish I was dead please let me die. The administrator on call and the resident's son were notified. The resident's son did not want the resident sent to the emergency department, and arrived at the facility to talk to the resident, who told his/her son s/he was just venting [his/her] feelings. Further review showed no follow up documentation. b. Review of a progress note dated 7/4/24 at 9:11 AM showed the resident sat in the hall and yelled at staff. Further review showed the resident stated I want to die; I am going to kill myself. RN #2 reported the resident's statement to the DON and the charge nurse. Further review showed no follow up documentation. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	c. Review of a progress note dated 9/21/24 at 12:40 PM showed CNA #1 reported a note was found on the resident's table that read, I wish I was dead; Please I was dead. The on-call administrator and resident's emergency contact were notified, and the emergency contact responded watch [him/her] and if you need any thing [sic] let me know. The plan was to monitor the resident. The resident was documented by CNA #1 as laughing with housekeeping staff at 12:50 PM, and sleeping comfortably at 1:55 PM and 3:32 PM. At 5:49 PM the resident was documented as screaming at the CNA. No further behaviors were documented on 9/21/24. d. Review of a progress note dated 11/6/24 at 7:25 AM showed CNA #2 answered the resident's call light. The resident was asleep, and the CNA saw a note on the resident's bedside table that read in part, I wish I was dead. The CNA texted LPN #1 a copy of the note, and the nurse immediately checked on the resident and found the resident asleep in his/her recliner in no obvious sign of distress. The nurse notified the DON and the NHA at 7:08 AM. The nurse called the resident's power of attorney (POA) at 7:24 AM and informed her about the note that was found in the resident's room. The POA stated she was aware the resident had these thoughts. The nurse informed the POA that the resident was asleep and not in current distress, and would be monitored by staff. e. Review of a progress note dated 11/6/24 at 9:41 AM showed a mental health agency was contacted by the administrator after being notified about the note. f. Review of a progress note dated 11/6/24 at 11:44 AM showed the mental health agency phoned to say a referral had been placed for local staff, and they would reach out with the best way to proceed. Further review of the medical record showed no evidence of any follow-up. g. Interview with the NHA on 11/13/24 at 4:54 PM revealed the mental health agency had stopped seeing the resident several months ago as they did not think their services benefited the resident. The administrator revealed the resident's daughter was called about the note on 11/6/24 and the facility was waiting on the mental health agency to proceed. No one-on-one was provided for the resident at the time the note was found. The facility did not have a current policy on suicidal behaviors. h. Interview with LPN #2 on 11/14/24 at 2:52 PM revealed the resident had been told s/he would need to be observed in the dining room if s/he mentioned any suicidal ideations. The nurse stated the resident would often say s/he didn't mean it. i. Interview with the social worker on 11/15/24 at 11:13 AM revealed she did not document conversations with residents; however, she communicated any resident behaviors to the nursing staff. Further, the interview revealed care plan interventions should be documented in the progress notes. 50485

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on medical record review and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (#98) reviewed for dementia care. The findings were: 1. Review of the 9/6/24 quarterly MDS assessment for resident #98 showed the resident was admitted to the facility on [DATE] and had diagnoses which included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and depression. The resident had a BIMS score of 4 out of 15 indicating severe cognitive impairment. Further review showed the resident was coded as being administered an antidepressant. A resident-initiated transfer to another long-term care facility occurred on 9/9/24. The following concerns were identified: a. Review of the Event Forms from 8/5/24 through 9/5/24 showed the resident had a resident-to-resident altercation with aggressive/combative behaviors on 5/10, 5/18, 7/13, 7/31, 8/18, 8/20, and 9/5. b. Review of the resident's care plan in the category of Resident-to-Resident Altercation, dated 9/4/24, showed the Approach section of the care plan gave a description of the resident-to-resident altercations which occurred on 3/2/24, 3/7/24, 3/11/24, 3/13/24, 3/15/24, 3/18/24, and 4/9/24; however, the care plan failed to include any interventions. c. Review of the Cognitive Loss/Dementia care plan, dated 11/29/23, showed interventions which included my staff will direct me to my room, activities, or meals as needed to assist me. and My staff will reassure my safety as needed if I am confused. d. Review of the Behavioral Symptoms care plan, dated 6/22/23, showed the resident may become verbally and physically aggressive and interventions included to .distract me with one of the robotic therapy animals, I tend to calm down better after I have been left alone for awhile (sic). and My staff will reassure me of my safety and explain what they are doing when they are helping me. e. Review of an Office Physician Progress Note, dated 5/1/24, showed Patient is easily awoke with verbal cue. Initially disgruntled but noncombative and became interactive. Per nursing staff patient does have strong medications that are causing [him/her] to be somnolent and rarely gets out of bed until later in the afternoon. No other acute concerns per nursing staff. Further review of the progress note showed no assessment or behavioral care plan had been developed. f. Review of an Office Physician Progress Note, dated 7/18/24, showed Patient continues to be extremely somnolent and does not react well to being woken up during any encounters. Per nursing staff and director of nursing they have no acute complaints at this time . Further review of the progress note showed no assessment or behavioral care plan had been developed. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Review of a progress note, dated 8/29/24, showed Resident was on the schedule today at 1 PM for a counseling appointment. Looking into [his/her] chart and on the appointment it was unclear where this was supposed to be at. Further the note stated the mental health agency had been called and no one had [the resident] in their records. Patient at this time has been combative so this appointment has been canceled at this time due to behavior as well not knowing where this was to be at. h. Review of the 6/12/24 Interdisciplinary Care Plan Conference Record showed the social service director had no concerns, nursing staff addressed the need for dental work, the family were happy to hear the resident had gained weight, and activities and dietary had no concerns. There was no documentation the resident's behaviors had been discussed. i. Interview with the social worker on 11/15/24 at 11:12 AM revealed she was involved in the resident's care; however, she does not document the encounters in the resident's record. Further, resident's behaviors were communicated to the administrator or the nursing staff and they made the decisions. j. Interview with the former NHA on 11/15/24 at 11:43 AM confirmed the facility failed to have a system in place to ensure a professional evaluation of the resident's behaviors was completed and effective interventions were developed. In addition, the former NHA revealed the medical director had not been consulted.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure medically related social services were provided for 1 of 1 sample residents (#4) reviewed with a PASRR (Preadmission Screening and Resident Review) Level II. The following concerns were identified: 1. Review of the 9/13/24 quarterly MDS showed resident #4 was readmitted from the hospital to the facility on [DATE] and had diagnoses which included cerebrovascular accident, non-Alzheimer's dementia, depression and bipolar disorder. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident did not exhibit physical or verbal behavioral symptoms or rejection of care. Review of the resident's care plan dated 3/22/23 showed When I have suicidal ideations or similar behaviors my staff will try to redirect me, they may offer me to call my counselor that I see or my family. They may take me to the common area or dining room to visit and interact with people and so my staff can ensure my safety. Further review showed the resident received antipsychotic medication and antidepressant medication, and the last gradual dose reduction was clinically contraindicated by the physician on 2/21/24. The following concerns were identified: a. Review of the PASRR Level II dated 4/15/21 recommended rehabilitative services to be provided in the nursing facility which included supportive counseling from nursing facility staff, minimum of an annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis, and an appropriate treatment plan. b. Review of the resident's medical record showed no evidence an annual psychiatric evaluation had been completed. c. Review of a progress note, dated 7/19/24, showed the resident told helping hand aide #1 s/he was not happy at the facility and wanted to look into moving to another facility. The aide notified the social services director and the DON. Further review showed no documentation or follow-up to this conversation. d. Interview with the social worker on 11/15/24 at 11:13 AM revealed she did not document conversations with residents, and she took any resident behaviors to the nursing staff. In addition, the social worker revealed care plan interventions should be documented in the progress notes.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 50485 Based on staff interview, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 43. The findings were: 1. Interview with the dietary manager on 11/14/24 at 2:08 PM revealed she had not completed the Certified Dietary Manager coursework; however, planned to have it done soon. Further interview with the dietary manager revealed the facility had a dietician on site every Tuesday for 8 hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37220 Based on staff interview and policy and procedure review, the facility failed to implement a water management program to prevent, detect, and control the risk of water-borne pathogens. In addition, the facility failed to conduct an annual review of its infection prevention and control program (IPCP). The census was 43. The findings were: 1. Review of the facility's Infection Prevention and Control Program policy showed it was implemented on 5/22/23. There was no evidence the facility had conducted an annual review of its IPCP and updated their program, if necessary. 2. Review of the 5/22/23 IPCP policy showed .17. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with DCC's water systems. c. The Maintenance Director along with the Safety Committee serves as the leader of the water management program. Review of the 5/2021 Legionella Surveillance policy showed .2. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies. These strategies included diagnostic testing, investigation for a facility source of Legionella, physical controls, and temperature controls. There was no documentation the facility had performed the primary prevention strategies. 3. Interview with the former NHA on 11/15/254 at 11:34 AM confirmed the IPCP policy had not been reviewed in the past year and no documentation was available to show the water management program had been implemented.