

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar Street Casper, WY 82601	

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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603</p> <p>Based on medical record review, resident interview, staff interview, and review of incident investigation documentation, the facility failed to ensure residents were free from sexual abuse for 1 of 5 sample residents (#1). The findings were:</p> <p>The facility had implemented the corrective action prior to the survey and was determined to be in substantial compliance as of 3/29/24. The facility was in past non-compliance.</p> <p>1. Review of resident #1 (victim) medical record showed a significant change MDS assessment dated [DATE], which showed the resident had a BIMS score of 12 out of 15 (moderately cognitive impaired). The diagnoses included non-Alzheimer's dementia, hemiplegia, dysarthria following cerebral infarction, blindness right eye, seizure disorder, and adjustment disorder with mixed anxiety and depressed mood. Review of the care plan showed Risk for elopement. Disoriented to place, Impaired safety awareness, resident wanders aimlessly dated 9/15/23. The Vision status showed the resident as legally blind in [his/her] right eye and adequate vision to the left eye. Further review showed under communication status .able to verbalize [his/her]needs albeit mod (sec) cognitive loss per BIMS. Status post S/P WMC admit for urinary tract infection with associated Acute Kidney Injury (AKI) and metabolic encephalopathy which has not completely cleared - per family (resident name) is alert and orientated times 3, and cognitive intact at baseline - staff reports frequent confusion, disorientation - Risk for unmet needs dated 9/13/24.</p> <p>2. Review of resident #2 (perpetrator) medical record showed a quarterly MDS assessment dated [DATE], which showed the resident had a BIMS score of 13 out of 15 (moderately cognitive impaired). The functional limitation in range of motion showed no impairment for the upper extremities, and impaired on both sides for the lower extremities. The diagnoses included non-Alzheimer's dementia, Parkinson's disease, cognitive communication deficit, unspecified voice and resonance disorder, adjustment disorder with anxiety, and insomnia. Review of the care plan showed, the resident was noted to wander the facility. No pattern was noted in regard to time of day. S/he on multiple occasions had been reported to attempt to enter the room of other residents and get in their beds. [Resident name] has on two occasions entered the room of female residents uninvited and attempted to behave in a sexual manner towards them. [S/he] often makes sexual comments towards female staff. [Resident name] at times may become physically aggressive towards staff when attempts at redirection are provided. Date Initiated: 03/22/2024. Document all behaviors, interventions, and communication with resident's spouse in progress note. Frequent checks, noting location within the facility and activity. Date Initiated: 03/22/2024.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 535049
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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>3. The following concerns were identified:</p> <p>a. Review of the incident report dated 3/15/24 at 7:15 PM showed the perpetrator was in the victims room with his/her pant down around the ankle. The perpetrator told the nurse they were just talking as s/he was escorted out of the room.</p> <p>b. Review of the 3/19/24 at 4:55 PM, event note showed during the evening med pass the RN went to resident #1 room, knocked on door and upon opening saw [resident #2] in his/her room off to the side of [resident #1] wheelchair. S/he was standing up out of his/her wheelchair facing [resident #1] and his/her pants were down around his/her ankles, his/her back to the door. From what the nurse could see his/her brief was still up. When the nurse announced herself and entered the room resident #2 quickly pulled up his/her pants and sat back down in his/her wheelchair stating she's fine, she's right here, she's fine. When the RN questioned what s/he was doing in resident #1 room with the door shut s/he claimed they were just talking. Resident #2 was immediately escorted out of resident #1 room, educated that s/he was not allowed to enter other resident's rooms and of the inappropriateness of his/her behaviors. S/he was then returned to his/her appropriate hall to be further monitored by the assigned nurse. Upon removal of resident #2, resident #1 was asked if s/he was ok and what the resident was doing when RN had entered his/her room. Resident #1 verbalized that the resident did expose his/her genitalia to him/her and told him/her that s/he wanted to stay. Resident #1 also stated more than once that the resident needed to leave and was out of control. During an interview with a police officer, resident #1 stated that resident #2 had masturbated in front of him/her (did not finish) and stopped when s/he told him/her to stop. S/he stated I don't know why s/he is like this. Resident #2 corroborated these statements when the police officer spoke with him/her about the incident. Resident #2 was returned to his/her room, where s/he opted to get in bed for the night. The on call Manager, DON and Executive Director were immediately notified of incident at 7:20 PM and multiple attempts to notify resident #2 spouse were made. Several messages left with no return call until the next day. Copy of this note will also be faxed to resident #2 doctor. Further monitoring placed on resident #2 to prevent re-occurrence of any future incidents in facility. Police investigation started and resident #2 corroborated events as resident #1 had stated them.</p> <p>c. Attempted to interview the victim multiple times during the survey without success. The resident was either not in the room or was asleep.</p> <p>d. Interview with the perpetrator on 4/8/24 at 10:10 AM revealed s/he felt safe in the facility. The resident stated in regards to the allegation that s/he was not touching myself. It was a joke grabbing my crotch, I did not drop my drawers or grabbed my nuts. During the interview this surveyor observed staff checking on the resident.</p> <p>e. Review of resident #2's location checks every 15 minutes showed on 3/14/24 the facility failed to show the resident location from 6:30 AM until 2 PM (7.5 hours). On 3/15/24 the facility failed to show the resident location from 4:15 PM through 7:15 PM (3 hours).</p> <p>f. Interview with LPN #1 on 4/8/24 at 10:17 AM revealed the perpetrator was on frequent checks 15 minutes to make sure s/he was not where s/he should not be.</p> <p>(continued on next page)</p>		

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