STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	**4041 SOUTH POPLAR STREET CASPER, WY 82601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 4/8/24 to 4/9/24. The survey was prompted by complaint intake WY000003835. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/23/2024

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F 600	Continued From page 1 by: 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: 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. 1. Review of resident #1 (victim) medical record showed a significant change MDS assessment dated 3/19/24, 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. 2. Review of resident #2 (perpetrator) medical	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

record showed a quarterly MDS assessment dated 2/23/24, 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."

3. The following concerns were identified:

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.

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

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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

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F 600	Continued From page 4	F 600		

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.

c. Attempted to interview the victim multiple times during the survey without success. The resident was either not in the room or was asleep.

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.

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).

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.

4. Review of the facility investigation showed the initial allegation was verbal between residents, and was not reported as abuse to the administration. The allegation was reviewed by the IDT team and saw that it was instead a physical abuse and reported it right away. The facility contacted the physician, the spouse, and the police.

5. The residents were separated at the time of the incident. The staff then again started monitoring resident #2's location. Other residents

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F 600	Continued From page 5 were interviewed related to their safety. Staff were interviewed related to the resident. 6. The facility investigated the incident appropriately. The facility implemented daily audits of the 15 minute check sheet by the DON. The audits were taken to the QAPI committee.	F 600		