| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 10/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>Casper, WY 82601 |

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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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on medical record review, resident and staff interview, and review of the facility's investigation, the facility failed to ensure residents were free from abuse for 1 of 6 sample residents (#1) with allegations of abuse. This failure resulted in actual harm to resident #1 who suffered pain, bruising, and emotional trauma resulting from assault by a staff member. Corrective measures were implemented by the facility and compliance was determined to be met on 10/4/21. The findings were:<br><br>1. Review of the 8/7/21 quarterly MDS assessment showed resident #1 was admitted to the facility on [DATE] and had diagnoses which included seizure disorder, anxiety disorder, and respiratory failure. Further review showed the resident had a BIMS score of 15 out of 15 (indicating the resident was cognitively intact), did not exhibit hallucinations or delusions; and required supervision for all ADLs except for bathing which was coded as dependent with the physical assist of 1 staff member. Review of a Head to Toe Skin Check dated 9/24/21 and timed 7 AM showed the resident had Intact Skin. Review of the facility's Suspected Abuse Investigation form showed an investigation was started on 9/25/21 at 10:15 PM following an allegation of sexual abuse. The following concerns were identified:<br><br>a. Interview with the resident on 10/14/21 at 2 PM revealed on the evening of 9/25/21 s/he was in bed for the night when CNA #1 came into the room with a flashlight, sat down in the recliner next to the bed, reached out with his hand and then squeezed the resident's left breast so hard it hurt and left the room. The resident stated s/he was angry and followed CNA #1 out of the room and into a room across the hall where s/he yelled at CNA #1 and called him a bastard. Further, the resident stated s/he was so scared by the incident s/he had pulled the tubing from his/her oxygen concentrator so hard the humidifier bottle full of water had fallen out. The resident stated the police had come the following day and photographs of his/her breast had been taken.<br><br>b. Interview with resident #2 on 10/14/21 at 2:20 PM, who resided in a room across the hall from resident #1, revealed on 9/25/21 CNA #1 was in his/her room when resident #1 came in very upset and stated CNA #1 had touched him/her.<br><br>c. Interview with LPN #1 on 10/14/21 at 6:35 PM revealed on 9/25/21 she had finished passing medications on hall 2 and was coming into hall 1, when the resident, who appeared anxious and very upset, indicated s/he needed to talk to her. LPN #1 stated the resident told her he squeezed me and indicated his/her left breast. A skin assessment was done at that time with no findings noted. LPN #1 then notified the night supervisor of the allegation. LPN #1 stated the resident was cognitively intact and well aware of everything that goes on and his/her main problem was anxiety.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | d. Interview with the night supervisor (LPN #2) on 10/14/21 at 6:50 PM revealed CNA #1 had told her he had been taking vital signs when the resident followed him into the next room and called him a bastard. LPN #2 removed CNA #1 from his duties and notified the manager on call of the allegation. In addition, LPN #2 stated the resident was very upset, informed her CNA #1 had grabbed his/her breast so hard it hurt, and did not want CNA #1 in his/her room. LPN #2 stated the resident was cognitively intact and she thought the resident was very truthful.<br><br>e. Interview with the ADON on 10/14/21 at 2:22 PM revealed she was the manager on call on 9/25/21 and had been notified of an allegation of abuse from the night supervisor. The ADON stated CNA #1 had told her he had been in the resident's room taking vitals and when he took off the blood pressure cuff he had bumped [the resident's] breast. In addition, the ADON stated CNA #1 asked if he could listen at the door when the resident was interviewed. The ADON instructed CNA #1 he could finish his charting in the breakroom and then instructed him to vacate the facility; however when she exited the resident's room after the interview, CNA #1 was standing in the hallway. The ADON stated when she woke up the resident for an interview the resident asked Are you here because of the man that came in with the flashlight, sat in the recliner, and grabbed my breast?<br><br>f. Review of the skin assessment dated [DATE] and timed 11 AM (approximately 12 hours after the incident) showed the resident had Bruising to left breast. Blue/purple circular bruise with smaller circular bruises that are darker. No other skin issues noted. Assessed breast last night at approx 2230 [10:30 PM] and no bruising was noted. Today bruising to left breast is visible. Review of the skin assessments dated 10/3/21 and 10/10/21 noted the bruises were resolving and were light purple and yellowish in color.<br><br>g. Interview with LPN #3 on 10/14/21 at 2:10 PM revealed the resident was adamant that CNA #1 had grabbed his/her breast on purpose because it hurt a lot. LPN #3 stated she had taken photographs of the bruising with the police camera the day after the incident and the bruises were still visible now. Further LPN #3 stated the resident was cognitive enough to describe what happened to him/her and remembers from day to day.<br><br>h. Telephone interview on 10/15/21 at 10:24 AM with CNA #1 revealed he obtained vital signs on the resident in bed A and then approached resident #1 who was awake and sitting in a recliner watching television. CNA #1 stated he always obtained vital signs in the same order starting with the resident's oxygen saturation level and pulse, body temperature, respirations per minute, and ended with blood pressure using a manual cuff. CNA #1 stated after he had completed the resident's vital signs, s/he followed him into a room across the hall and called him a sick man and a sick bastard. Further, CNA #1 stated the facility told him to complete his charting and leave the facility. CNA #1 denied grabbing the resident's breast.<br><br>i. Review of the 9/25/21 Hall 1 Vital Signs worksheet showed CNA #1 had documented he had obtained vital signs on 11 residents on hall 1, however interview with resident #1 on 10/14/21 at 2 PM revealed CNA #1 had not obtained his/her vital signs. Interview with the ADON on 10/14/21 at 2:22 PM revealed the cognitive residents on hall 1 were interviewed with 100% of them stating their vital signs had not been taken by CNA #1. Interview with the NHA on 10/15/21 at 12:20 PM confirmed 10 cognitive residents on hall 1 had been interviewed and all of them reported their vital signs had not been obtained by CNA #1.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | j. Review of the facility's investigation showed the resident followed CNA #1 out of his/her room on 9/25/21 at 10:15 PM visibly upset, and confronted him saying the he had inappropriately touched him/her. The investigation included interviews with staff and cognitive residents, and skin assessments on all non-cognitive residents on hall 1. Interviews with the cognitive residents on hall 1 revealed CNA #1 had not obtained vital signs on the evening of 9/25/21. The facility substantiated the allegation of abuse and false documentation as verified by bruising on Lt [left] breast of resident consistent in size and shape of finger prints, and multiple statements from residents that the CNA did not obtain their vitals which he had documented in the medical record. CNA #1's employment with the facility was terminated.<br><br>2. Review of the facility's corrective measures showed the following:<br><br>a. The facility terminated CNA #1's employment on 9/25/21.<br><br>b. A skin assessment was completed on all non-cognitive residents.<br><br>c. Education was provided to all employees on 10/4/21 which included the types of abuse, suspicious behaviors or signs of abuse a resident might demonstrate, reporting requirements, false documentation, and grievances and concerns. Review of the personnel roster showed 100 of 113 employees had been provided the education. Interview with the NHA on 10/15/21 at 12:20 PM revealed the remaining staff members were PRN employees and were required to complete the education prior to working their next shift. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>37220<br><br>Based on medical record review, observation, staff and resident interview, and review of the facility's investigation report, the facility failed to ensure residents were free from misappropriation of personal property for 3 of 5 sample residents (#3, #4, #5) who reported missing money to the facility. Corrective measures were implemented by the facility and compliance was determined to be met on 10/4/21. The findings were:<br><br>1. Review of the 8/17/21 quarterly MDS assessment showed resident #3 had a BIMS score of 15 out of 15 (indicating the resident was cognitively intact). The resident resided on hall 3. The following concerns were identified:<br><br>a. Interview on 10/14/21 at 12:44 PM with the resident revealed s/he kept his/her wallet in the top drawer of a dresser located next to the bed. Further, when s/he went to bed on the night of 9/28/21 the wallet contained $33, and in the morning only $4 was left. The resident stated s/he suspected a certain staff member of stealing the money, however s/he could not be certain and the staff member was no longer employed. Observation at that time showed a lock had been installed on the resident's dresser drawer.<br><br>2. Review of the 7/14/21 quarterly MDS assessment showed resident #4 had a BIMS score of 13 out of 15 (indicating the resident was cognitively intact). The resident resided on hall 3. The following concerns were identified:<br><br>a. Interview on 10/14/21 at 12:15 PM with the resident revealed his/her daughter had given him/her $200 which was kept in a watch box and in a dresser drawer. The resident stated s/he had spent some of the money, however $100 was missing which was reported to the staff member supervising smoke break. Observation at that time showed a lock had been installed on the resident's dresser drawer.<br><br>3. Review of the 9/16/21 quarterly MDS assessment showed resident #5 had a BIMS score of 14 out of 15 (indicating the resident was cognitively intact). The resident resided on hall 3. The following concerns were identified:<br><br>a. Interview on 10/14/21 at 1:50 PM revealed s/he had $42 in his/her wallet which was kept in a dresser drawer. The resident noticed it was missing on Casino Day and reported it to the lady in charge of it all. Observation at that time showed a lock had been installed on the resident's dresser drawer.<br><br>4. Review of the facility's investigation showed the money in all three cases went missing during the night shift on 9/28/21. The investigation began on 9/29/21. The investigation was able to identify 1 employee that worked hall 3 the night the money went missing. The employee denied the allegation and resigned effective immediately, however the facility was unable to prove the employee had stolen the money.<br><br>5. Interview with the NHA on 10/15/21 at 11:30 AM confirmed resident #3, #4, and #5 were cognitively intact and capable of managing and keeping track of their money. In addition, the NHA stated the facility was unable to prove the suspected employee had stolen the money.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Review of the facility's corrective measures showed the following:<br><br>a. Interviews were conducted with residents who resided on hall 3.<br><br>b. Locked drawers were offered to all residents.<br><br>c. The residents affected were reimbursed the stolen money.<br><br>d. Education was provided to all employees on 10/4/21 which included the types of abuse, suspicious behaviors or signs of abuse a resident might demonstrate, reporting requirements, false documentation, and grievances and concerns. Review of the personnel roster showed 100 of 113 employees had been provided the education. Interview with the NHA on 10/15/21 at 12:20 PM revealed the remaining staff members were PRN employees and were required to complete the education prior to working their next shift. |