STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	**4 NORTH FORK ROAD FORT WASHAKIE, WY 82514**

(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 on 11/8/18.. The survey was prompted by complaint intake WY00002731. The following common abbreviations are used through this document: CNA: Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	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 by: Based on observation, staff and resident interview, review of employee files, and review of the facility's investigation, the facility failed to ensure 1 of 1 sample residents (#1) identified in reported allegations of abuse and/or neglect,	F 600	Past noncompliance: no plan of correction required.	12/6/18

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

Electronically Signed | 12/06/2018

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.

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F 600	Continued From page 1	F 600		

were free from abuse and/or neglect. This failure resulted in past non-compliance at actual harm to resident #1 who was verbally abused by a staff member. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 8/9/18. The findings were:

1. Review of a facility incident report dated 8/9/18 showed CNA #1 was alleged to be "nitpicking" resident #1 during lunch and when the resident got upset the CNA told the resident if s/he didn't be quiet s/he was "going to get a cold shower." The incident alleged the CNA would "shove food" in the resident's mouth when the resident attempted to speak. Further it was alleged he said "if I had the chance I would bounce your head off the toilet," "Don't let that old bitch leave," "why couldn't [s/he] be a Jew in the holocaust," and "my fiancée loves [him/her] and would take [him/her] home if she could. If she ever did, [s/he] would never come back." The following concerns were identified:

a. Observation on 11/8/18 at 3:25 PM showed resident #1 was in the common area by the nurse's station. The resident appeared confused and ambulated with a front-wheel walker.

b. Interview on 11/8/18 at 4:01 PM with CNA #2 revealed she was a witness to the abusive behavior displayed by CNA #1 to resident #1. The CNA stated she witnessed CNA #1 "antagonize" the resident in the dining room telling him/her things such as "no one likes [him/her]" and he forced food into the resident's mouth when s/he tried to say something. The CNA revealed CNA #1 made statements to her and other staff about the resident such as, given the chance he would "bang [his/her] head on the toilet." CNA #2 reported the allegations to the administrator and

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F 600	Continued From page 2	F 600		

was interviewed as part of the facility's investigation.

c. Interview on 11/8/18 at 5:15 PM with CNA #3 revealed she was a witness to the abusive behavior displayed by CNA #1 to resident #1. The CNA stated CNA #1 talked about the resident to other staff. She overheard him make a threat such as "she may get a cold shower." The CNA reported the allegation to the administration and was interviewed as a part of the facility's investigation.

d. Interview with CNA #1 on 11/8/18 at 6:01 PM revealed he was told he was suspended and terminated for saying some "not so nice things about a resident." The CNA described the resident as having "extreme onset of dementia" and stated he had some "personal things" going on the day of the allegation. The CNA revealed he did not recall saying the alleged things; however, he did not deny the allegations and stated that it "sounded like something I would say." The CNA stated he felt like he was going to "implode" on the day of the allegation and he said things "like" the allegations "in his head." Further interview revealed the CNA felt bad about the incident and stated he "shouldn't have done it" as his behavior was "not appropriate."

e. Review of the Employee file showed CNA#1 had been hired in August 2015 and a background screen was completed at that time, with no findings. The employee received his CNA license on 1/6/16 and was included on the CNA abuse registry with no findings of abuse. The employee had a record of receiving education related to abuse and abuse prohibition, and had one disciplinary action in April of 2017 related to being overheard talking about residents and calling them names.

f. Interview with resident's #2, #3, and #4 on

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F 600	Continued From page 3 11/8/18 between 3:30 PM and 3:50 PM revealed there were no concerns about current staff or resident treatment. g. Review of facility documentation showed CNA #1's employment was terminated on 8/8/18. Interview with 10 facility CNAs on 11/8/18 from 4:41 PM to 5:24 PM revealed all were knowledgeable about requirements related to abuse and neglect. Further, the CNAs revealed the facility provided training related to abuse and neglect frequently, with the most recent training provided in October.	F 600		