STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535056	A. BUILDING _____ B. WING _____	C 04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

(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 3/12/19 to 4/1/19. The survey was prompted by complaint intake WY000002789.	F 000		
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 by: Based on medical record review, resident and staff interview, and review of the facility's incident report and investigation, the facility failed to ensure residents were free from non-consensual sexual contact for 1 of 1 sample residents (#1) with allegations of sexual interactions with staff. The findings were: 1. Review of the quarterly MDS assessment dated 2/7/19 showed resident #1 was admitted to the facility on 7/14/18, and had diagnoses which included neurogenic bladder, hemiplegia or hemiparesis, and depression. Further review	F 600	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the providers admission or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Corrective action:	4/18/19

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

Electronically Signed | 04/25/2019

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F 600	Continued From page 1 showed the resident had a brief interview for mental status (BIMS) score of 13 out 15 (indicating the resident was cognitively intact) and required extensive assistance of 1 person for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Review of an "Interdisciplinary Note" for the resident dated 2/26/19 showed the facility's interdisciplinary team reviewed an allegation of sexual abuse involving the resident. The resident reported CNA #1 had been sexually inappropriate with him/her during the resident's shower the evening of 2/19/19. Further review of the 2/26/19 "Interdisciplinary Note" showed an investigation was initiated, the resident presented with no change in baseline behavior, and the resident's care plan was updated. Review of the resident's care plan showed the item "Resident alleges inappropriate sexual contact with staff member" was initiated on 2/22/19. Interventions included the following: monitor for resident making inappropriate sexual comments towards staff, monitor for signs and symptoms of infection, monitor times 3 days for tearfulness, fearfulness, and changes in behavior, notify physician of any changes in behaviors related to allegation, and will refer to counseling as appropriate. The following concerns were identified: a. Review of the facility's investigation showed the resident was interviewed by the facility on 2/20/19 at 6:30 PM, and told the facility CNA #1 had sucked on his/her nipple, and washed the resident's genitals. The resident stated "...[CNA #1] told me I am the only one [s/he] is doing this with." b. Review of the facility's investigation showed the resident was interviewed by the facility again on 2/22/19 at 2:10 PM. At that time, the resident reported the sexual contact began in	F 600	Rt #1 was evaluated by nursing following 2/20/19 allegation for changes in baseline behavior with none noted. No physical injury present. Care plan was updated to include monitoring behavior, s/s infection, notifying MD of changes in baseline, inappropriate sexual comments towards staff and counseling as appropriate for Rt #1. Rt #1 was evaluated by social services director (SSD) to determine mood or behavioral concerns on 3/25/19 with no changes identified from prior to allegation. Abuse education was provided to CNA #1 by prior to first shift by staff development coordinator. CNA #1 was suspended pending investigation from SVCC on 2/20/19. He/she did not return to center following suspension with termination of employment date of 2/26/19. ID of others: A sample of other residents were interviewed on 2/25/19 by social services director to see if there were any residents who report being touched in an inappropriate or sexual way since admission to center. No residents report being touched in this way. An additional resident sample interview was conducted by social services director on 4/18/19. No residents report being touched in an inappropriate or sexual way since admission to the center. Systemic changes: Staff are educated on abuse prevention upon hire and at least twice annually thereafter. Staff abuse re-education was completed on 4/5/2019 by way of written handout and again on 4/10/19 from Hand	

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F 600	Continued From page 2 his/her room, when CNA #1 "rubbed up" on him/her, then continued in the shower where the CNA sucked on the resident's nipple and told the resident s/he wanted to have further sexual contact with the resident. The resident stated s/he expressed concern they would be caught, and asked the CNA "...how many other [guys/girls] are you doing this with?" The CNA responded, "You're the only one here. You're the only one I've found." The resident stated the CNA then took the resident's hand and put it down his/her pants. c. Interview with resident #1 on 3/12/19 at 12:40 PM revealed a CNA at the facility tried to make the resident "aroused" and "french-kissed" the resident in the shower. The CNA asked the resident to engage in sexual intercourse and the resident stated s/he couldn't. Continued interview revealed the CNA "licked" the resident's nipple and tried to perform oral sex; however, the CNA was unable to due to the resident's catheter. The resident revealed s/he allowed the interaction to continue and touched the CNA "a few times" as s/he "didn't know what else to do." The resident stated s/he told the CNA to quit and the CNA wouldn't. The resident stated the CNA stuck his/her hand down the CNA's pants and the resident felt the CNA's genitals. Further interview revealed the resident "didn't enjoy it, but let [the CNA] think [s/he] did" and the resident "...did not want it to happen." d. Interview with resident #2 on 3/12/19 at 1:50 PM revealed resident #1 was his/her roommate, and resident #1 had told resident #2 about the interaction in the shower. Resident #2 revealed s/he was told CNA #1 was "kissing," "fondling," and "rubbing on" resident #1 in the shower. e. Review of the facility's investigation showed CNA #1 was interviewed by the facility on	F 600	in Hand module 2 □what is abuse□ video by resident care manager. Monitoring: Allegations of abuse are reviewed monthly at QAPI for trends, education needs and proof of reporting Executive Director/designee will continue reporting allegations Q month to QAPI meeting. This allegation was reviewed at QAPI 3/21/19. Allegations of abuse will be reviewed at QAPI by interdisciplinary team monthly for 3 months or until QAPI determines change in ongoing monitoring frequency.	

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F 600	Continued From page 3	F 600		

2/20/19 at 6:50 PM. The CNA reported the resident was grabbing at him/her "everywhere." However, further review showed the CNA stated s/he did not report this behavior to a nurse or discuss it with his/her co-workers.

f. Further review of the facility's investigation showed the facility interviewed CNA #1 again on 2/21/19 at 4:30 PM. The CNA confirmed s/he gave resident #1 a shower. The CNA reported the resident was "moving [his/her] hands" over the CNA and tried to "get up" the CNA's shirt. The CNA stated s/he told the resident "no, we aren't going to do that," finished the resident's shower, took the resident to his/her room, and assisted the resident into bed. When asked if the resident "actually got [his/her] hands down into your pants" the CNA stated "Just an effort, I kept moving [his/her] hands aside and was like no, don't do that." The CNA stated s/he did not report this interaction with the resident because s/he did not want to get the resident "in trouble too."

g. Interview with CNA #1 on 3/12/19 at 1 PM revealed the CNA provided a shower to resident #1 and during the shower the resident was "putting [his/her] hands all over" the CNA. Further interview revealed during a transfer of the resident, the resident felt the CNA's genitals and the CNA did not report this due to feeling "embarrassed."

h. Review of the facility's investigation showed CNA #1 was an experienced CNA, with more than 9 years of nursing home experience.

i. Review of the facility's investigation showed a list of 11 staff members were asked between 2/20/19 and 2/25/19 if they had ever been "grabbed at" or touched in an inappropriate way by resident #1. All staff members denied resident #1 had touched or grabbed at them in an inappropriate way.

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F 600	Continued From page 4 j. Interview with the administrator on 3/12/19 at 2:48 PM revealed resident #1 reported CNA #1, by name, as being a "sex fiend." The resident reported that the CNA was "sucking on [his/her] nipples and wanted to do stuff." The resident reported the CNA had stuck the resident's hands down his/her pants, and the resident felt the CNA's genitals. The administrator revealed when CNA #1 was interviewed, the CNA reported resident #1 was trying to stick his/her hands down the CNA's pants and the CNA would not allow it. Further interview revealed the resident had no history of sexually inappropriate behaviors with staff. The administrator further stated the CNA's employment at the facility was terminated for "a rule violation of not reporting alleged inappropriate behaviors."	F 600		