STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 5/22/19 through 5/24/19. The survey was prompted by complaint intakes WY00002774, and WY00002831. The following common abbreviations are used through this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610	1. Residents #7 and #8 were identified as being affected. Both residents were re-interviewed and neither reported concerns of mistreatment. 2. No other residents were identified as being affected. All residents have the potential to be affected. Additional resident interviews were conducted on both wings regarding concerns of abuse or mistreatment and no residents reported feeling abused or mistreated. 3. All allegations of abuse will include interviewing additional residents and staff besides those who are directly involved in the allegation. All interviews will be documented and written statements will be obtained from staff involved in the allegation. Staff are being re-educated about obtaining additional interviews and of getting written statements from staff who are involved in the allegation as per facility policy. 4. The Administrator and/or designee will review all abuse allegation investigations to verify compliance with the procedure. Results of reviews will be reported monthly to QAPI for the next 90 days.	6/11/19

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

Administrator 6-18-19

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 610	Continued From page 1 Based on facility incident log review, medical record review, staff interview and review of facility policy and procedure, the facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 4 investigated allegations of abuse (involving residents #7 and #8). The findings were: 1. Review of the 5/4/19 quarterly MDS assessment showed resident #7 had diagnoses which included non-Alzheimer's dementia and short-term memory loss. Further, the resident had a BIMS score of 4 (severely cognitively impaired) and did not display physical or verbal behavioral symptoms. Review of the corresponding care plan showed interventions for anxiety related to memory loss included ..."will ask the same question over and over. Be patient and once the question is answered attempt to re-direct ..." The following concerns were identified: a. Interview on 5/22/19 at 2:50 PM with employee #1 revealed the following information. The employee was working as a CNA-in-training around midnight when she heard CNA #1's interactions with the resident. The incident occurred at some time during the first two weeks in April 2019. The resident was sitting in the nurse's station area, and repeatedly asked about his/her spouse. CNA #1 responded to the resident in a loud voice, "your [spouse] is dead, just get over it". The resident became more agitated and the questions were repeated over and over. The resident's agitated behavior was concerning because all direct care staff knew that giving a reassuring response to the resident's questions about his/her spouse reduced his/her anxiety level. That day, the employee reported the incident to LPN #1, who was the charge nurse at that time; and later reported the same concerns	F 610		

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F 610	Continued From page 2 to the administrator. b. Interview on 5/31/19 at 3:35 PM with CNA #1 revealed he did not recall the date or time, but remembered telling the resident his/her spouse had passed away because at that time he understood responding truthfully was the best response. The CNA stated he learned this response was not the best response because it caused the resident to become more agitated and sometimes it took 2 or 3 hours to calm him/her. The CNA denied telling the resident to get over it. c. Review of the facility investigation showed their investigative process did not include determining whether other residents and staff had experienced or were aware of similar incidents involving CNA #1. d. Interview on 5/24/19 at 8 AM with the clinical social worker revealed she investigated the allegation and provided additional dementia care training for CNA #1. She stated the investigation consisted of interviews with the CNA-in-training, CNA #1, and LPN #1. She verified additional staff and other residents were not interviewed. 2. Review of the 3/30/19 quarterly MDS assessment showed resident #8 had diagnoses which included Parkinson's Disease and dementia. Further, the resident had a BIMS score of 15 (no cognitive impairment); required assistance with toileting and personal hygiene care; and did not display physical or verbal behavioral symptoms. Review of the corresponding care plan showed interventions included directions for staff to set strong boundaries with the resident and if the resident was inappropriate either redirect or ensure safety and return later. Review of the facility incident logs showed the resident reported physical abuse	F 610		

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F 610	Continued From page 3 by CNA #4 on 3/1/19. Review of the investigation report showed the findings were determined to be unsubstantiated. The following concerns were identified: a. According to the investigation, the unsubstantiated findings were primarily based on information received from CNA #2 and CNA #3 who heard the interaction between the resident and CNA #4 during the incident. The 2 staff members provided information that did not support the allegation. However, further review showed no documentation or statements of the information the 2 CNAs provided. Nor were there documented interviews with other residents. b. Interview on 5/24/19 at 8 AM with the clinical social worker revealed she interviewed CNA #2, CNA #3, CNA #4, and resident #8; but she did not document the interviews with CNA #2 and CNA #3 or obtain written statements. She verified additional staff and other residents were not interviewed. 3. Review of Policy No. WRC-2 titled, "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to- Resident Altercations", updated January 2019 showed the following procedures were included in the investigation and protection process: a. Interview staff members as appropriate who have had contact with the resident during the period of alleged incident or who may have pertinent information about the incident. b. Interview other residents to whom the accused employee provides care or services. c. Witnessed reports will be reduced to writing. Witnesses will be required to sign and date such reports.	F 610		