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 10/02/2020

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 9/21/20 through 10/02/20. The survey was prompted by complaint intake WY00003079. In addition, a COVID-19 focused infection control survey which included a review of emergency preparedness requirements was conducted. It was determined, based on the findings of the survey team, that no deficiencies were identified related to the infection control survey. The following common abbreviations are used throughout this document. CNA: Certified Nursing Assistant MDS: Minimum Data Set NSA: Nursing Support Assistant Less commonly used abbreviations will be annotated in each deficiency.	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	F 600		10/7/20

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

Electronically Signed | 11/12/2020

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 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility incident reports, medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents (#3) reviewed for abuse. The findings were: Review of the 9/5/20 quarterly MDS assessment showed resident #3 had diagnoses which included bipolar disorder, Parkinson's disease, renal insufficiency, and hypertension. Further review showed the resident had a BIMS (Brief Interview for Mental Status) score of 2, indicating severe cognitive impairment, and was not coded as exhibiting rejection of care during the 7-day look-back period. Review of the 6/15/20 "Facility Incident Report" showed the facility investigated an incident wherein CNA #3 allegedly struggled with the resident and reportedly withheld his/her glasses from him/her. It was further alleged CNA #3 told the resident "See ya asshole" at the end of the shift. The following concerns were identified: 1. Review of the "Facility Incident Report" dated 6/15/20 showed a complaint about CNA #3's behavior was reported and investigated. It was documented a security camera had recorded that CNA #3 approached resident #3, who was seated in a recliner in the common area at 5:52 AM on 6/15/20, and attempted to assist the resident out of the chair. A "stand lift" (a mechanical device used to assist in standing from a sitting position) was attempted, however the transfer was unsuccessful due to the resident's resistance.	F 600	F600 1. Resident #3 was identified as being affected. Resident #3 had no signs of being distressed at the time of the incident and thereafter. 2. No other residents were identified as being affected. All residents have the potential to be affected. 3. The staff member was immediately removed from the facility at the time of the incident report and was terminated. Mandatory re-education was conducted with all staff members about abuse policies covering types of abuse, prevention of abuse and reporting allegations of abuse. 4. Administrator and/or designee will conduct random observations weekly of staff interactions with at least 3 non-interviewable residents and will conduct interviews with at least 3 residents on each unit (North and South). The resident interviews will address how the resident is being treated by staff and others. 5. Administrator and/or designee will report results of observations and resident interviews to QAPI committee monthly for the next 90 days to monitor for any concerns regarding staff interactions with	

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F 600	Continued From page 2 Further review showed CNA #2, CNA #3 and NSA #1 approached the resident at 6:11 AM and were seen speaking to him/her. It was reported that CNA #3 told the resident "See ya later asshole" at that time. 2. Review of the statement written by NSA #1 on 6/15/20 showed she had witnessed CNA #3 approach the resident and say into his/her right ear "See ya later asshole." 3. Interview with NSA #1 on 10/1/20 at 2:57 PM revealed she and CNA #3 approached resident #3 to get him/her up from a chair in the common area on the morning of 6/15/20. The resident did not want to be disturbed and resisted care by grabbing the CNA's arm. The CNA then held the resident's glasses away from him/her and said "I won't give them back until you let go." NSA #1 stated "Being an NSA and in orientation I was not allowed to assist in direct resident care." Further interview revealed CNA #3 had previously stated she did not like resident #3 and did not want to work with him/her. "I never heard [CNA #3] use profanity with the residents before this, but she used profanity all of the time in the break room. When we left work, [CNA #3] went to [resident's name] and told [him/her] 'See ya asshole'." 4. Review of the statement written by CNA #2 on 6/16/20 showed "When leaving at 6 AM [CNA #3] went over to [resident's name] pulled [his/her] mask down and said 'bye asshole' and walked away." 5. Interview with CNA #2 on 10/2/20 at 10:54 AM revealed on the morning of 6/15/20 "We [CNA #3 and myself] went to get [resident #3] up." The resident had resisted earlier and still refused to	F 600	residents. The QAPI committee will evaluate results to determine if current plan of correction is effective or if additional training is needed and will revise plan as necessary to ensure compliance.	

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F 600	Continued From page 3	F 600		

get up, even with the lift. The resident grabbed CNA #3's arm. She then took the resident's glasses and said "I won't give them back until you let go." When released she threw the glasses back to the resident. CNA #2 stated, "When we left she said 'bye asshole'."

6. Interview with the social service director on 9/21/20 at 3:11 PM confirmed she had been involved in the investigation. Further, CNA #3 was placed on administrative leave 6/15/20 and ultimately her employment at the facility was terminated.

7. An attempt was made to interview resident #3 on 9/21/20 at 2:12 PM, however, the resident could not be interviewed due to severe cognitive impairment. Answers to questions were one word responses, and parroted the last word of the question.

8. Interview with CNA #3 on 10/2/20 at 4:25 PM revealed "[Resident's name] has hurt people before. [His/her] glasses fell off and I was trying to put them back on. When [s/he] kept fighting and flaying around I put [his/her] glasses back on and decided to wait for day shift to help get the resident up." Further interview revealed the CNA denied the allegations, stating, "I think the brand new NSA thought I handled it wrong. I don't know where they got the idea I call [him/her] an asshole..."

9. Review of the policy titled "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" issued in September 1999 showed "The resident has the right to be free from abuse, neglect, misappropriation of resident property,

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F 600	Continued From page 4 and exploitation ...It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology." In addition "All employees and contract agency staff will be informed of the facility's abuse/neglect prohibition, prevention and reporting policies during the annual employee orientation. New employees will be informed of these policies during their initial orientation and annually thereafter during their annual employee orientation. Additional training may be conducted as needed."	F 600		