STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	**1330 PRAIRIE AVENUE CHEYENNE, WY 82009**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 8/5/21 to 8/6/21. The survey was prompted by complaint intake WY00003243. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys on 8/5/21 through 8/6/21. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the infection control survey. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Assistant MDS: Minimum Data Set RN: Registered Nurse 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	F 600		8/30/21

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

Electronically Signed | 08/30/2021

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F 600	Continued From page 1 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 staff interview, former employee interview, review of incident reports, review of facility investigation information, and review of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix PP, the facility failed to ensure 1 of 4 sample residents (#2) was free from mental abuse a reasonable person would find threatening. The findings were: Review of the 6/5/21 quarterly MDS assessment showed resident #2 had diagnoses that included dementia and had severe cognitive impairment with a BIMS score of 3 out of 15. The resident was not coded as having any physical or verbal symptoms toward others and the resident required extensive physical assistance of one staff person for toileting and personal hygiene needs. Review of the 6/1/21 facility incident report showed the resident was the alleged victim of verbal abuse from CNA #1. The report showed CNA #1 was overheard by CNA #2 to say she would "hit [the resident] back" when the resident threatened to hit the CNA. The report showed the facility provided protection by suspending CNA #1 during the investigation, and the CNA was dismissed from her employment upon completion of the investigation. The facility concluded abuse did not occur, however, review of the CMS State Operations Manual Appendix PP showed "Mental	F 600	1. Investigation completed, another investigation not pertinent. Alleged perpetrator terminated. 2. All allegations of abuse will be reviewed using CMS definition of abuse in F600, starting 8/27/2021. 3. Re-education provided to all staff in regards to abuse policy by ED or designee by 9/30/2021. 4. Audit tool will be created by 9/3/2021 and utilized for all abuse investigations. The ED will present audits to QAPI monthly for review and feedback for a minimum of 3 months to ensure compliance is achieved and maintained.	

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F 600	Continued From page 2	F 600		

abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability." The following concerns were identified:

1. Interview with the administrator on 8/5/21 at 4:30 PM revealed he was contacted regarding the incident and started the investigation that night. He confirmed there had been nothing significant to his knowledge to cause the night to be especially difficult or out of the ordinary. He stated he interviewed each CNA and documented his interview findings. He verified CNA #1 admitted to telling the resident she would hit him/her back when the resident threatened to hit her. The administrator also stated the resident was hard of hearing and the CNA reported to him the resident did not hear or react to the statement. The administrator stated the resident was assessed by nursing staff and there were no physical findings of abuse or any fear or behavioral symptoms identified. He further stated he had interviewed the resident that night and s/he denied any staff mistreatment or threats. He confirmed the determination made by the investigation was to terminate CNA #1's employment for unprofessional behavior. The facility did not conclude verbal abuse had occurred due to the inability of the resident to hear the CNA's threat.

2. Review of the facility's investigation showed the administrator interviewed CNA #1 on 6/1/21 at

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F 600	Continued From page 3	F 600		

midnight. Documentation of the interview showed CNA #1 reported the resident was "yelling at her" asking "what are you doing?" The CNA stated she was talking to the resident "very loudly", and told the resident she was cleaning urine off him/her. The resident could not hear and then yelled at the CNA, "I'm going to hit you if you don't stop." CNA #1 replied, "if you hit me I'll hit you back." CNA #1 stated CNA #2 then entered the room and took over. CNA #1 further stated, "I should have not said it. [The resident] did not hear me or react to what I said."

3. Interview with CNA #2 on 8/5/21 at 1:40 PM confirmed she had witnessed and reported the allegation of verbal abuse against CNA #1. She recalled she was working that night with CNA #1, and at the end of night room rounds they found resident #2 had been incontinent and required toileting and personal care. The resident's wheelchair also needed to be cleaned. CNA #2 stated she took the wheelchair to the shower room to spray it off and CNA #1 took the resident into the bathroom to provide needed care. When she returned to the room, CNA #2 reported standing in the entrance of the room where she overheard the resident saying s/he was going to hit CNA #1, and CNA #1 responded to the resident by saying that she would hit or punch the resident back. CNA #2 could not recall the exact words, however, she stated it was to this effect. She stated when she heard CNA #1 threaten to hit the resident she came further into the room and confronted CNA #1 saying, "You can't do that." She stated CNA #1 then gathered her things and left the building. CNA #2 reported the incident to the nurse, and the administrator was notified.

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F 600	Continued From page 4 4. Interview with CNA #1 on 8/5/21 at 1:27 PM verified she had cared for resident #2 and she recalled the incident. She stated when she and another CNA went to the resident's room, the resident required toileting care due to an incontinence accident. CNA #1 stated it had been a "rough night." She explained it was busy and it was the end of the shift and the resident was hitting her while she was providing care. She could not recall exactly what she said, however she remembered saying something about "hitting [the resident] if [s/he] hit me." She then stated it was out of "ear shot" because she had walked away from the resident and made the statement to the CNA who was working with her. During the interview, CNA #1 could not recall which CNA she had been working with that night. The CNA verified she had been interviewed by the administrator as part of the verbal abuse investigation and she told him she had made a statement about "hitting the resident back." CNA #1 further stated that she put in her two week notice at the end of the interview with the administrator.	F 600		