STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 2/27/23 to 2/28/23. The survey was prompted by complaint intake WY00003536. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set NHA- Nursing Home Administrator 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 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		3/17/23

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

Electronically Signed | 03/15/2023

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F 600	Continued From page 1 by: Based on medical record review, staff and resident interviews, and review of facility documentation, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 of 1 sample residents (#1) reviewed for abuse allegations. The findings were: 1. Review of the 11/18/22 quarterly MDS assessment showed resident #1 had a BIMS score of 6, which indicated severe cognitive impairment. The resident exhibited verbal behavioral symptoms directed at others 1 to 3 days in the 7 day look-back period. Review of the 2/7/23 quarterly MDS assessment showed the resident had a BIMS score of 2, which indicated severe cognitive impairment. The resident exhibited verbal behavioral symptoms directed at others 1 to 3 days in the 7 day look-back period. The following concerns were identified: a. Review of the facility's documentation "Human Resources Fact Finding Summary" showed on 1/30/23 the NHA (who was the director of nursing at that time) received two allegations of abuse of resident #1 by CNA #1. Further review showed CNA #2 reported on 1/25/23 she witnessed CNA #1 being rough with the resident while they were trying to roll him/her in bed. CNA #1 shoved the resident so hard the resident was "smacked up against the bed rail." CNA #1 then yelled obscenities at the resident and called him/her "an asshole." CNA #2 reported it to LPN #1. Further review showed a second allegation reported on 1/30/23 was reported by environmental services (EVS) supervisor #1. She reported that she overheard the resident saying "Ow! Ow! What are you doing that for? " and CNA #1 replied to the resident "You're a dick. That's why." She stated CNA #3 was also present during	F 600	F600 – Resident #1 interviewed and denies any identified concerns related to incident. Physical assessment performed following incident and no physical injury identified. Behavior monitoring continued following incident with no identified behavior changes. CNA #1 immediately placed on administrative leave and following investigation, terminated from facility. All other residents identified to be at risk for abused from employee identified in complaint. Follow up interviews completed with multiple other residents and no other concerns of abuse identified. All staff from all departments that work in or are exposed to nursing center or nursing center residents will be provided with abuse and neglect training including signs of abuse and neglect and importance of timely reporting and who to report to by March 17, 2023. Nursing staff will perform monitoring on each 12-hour shift for signs of abuse and document any signs and/or potential cases of abuse. DON or administrator will be immediately notified of any potential abuse cases. Abuse monitoring report will be reviewed by QAPI committee at least quarterly to monitor for any future episodes of potential abuse. Any reports of potential abuse will be reviewed by QAPI committee to identify trends.	

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F 600	Continued From page 2	F 600		

the incident. She reported she thought the incident occurred on 1/11/23. Further review of the documentation showed the facility's conclusion after their own investigation was "The veracity of both allegations against [CNA #1]'s abuse of resident 1 have been substantiated, even though [CNA #1] denies the allegations...Two different employees from two different departments reported allegations of abuse by [CNA #1] involving two separate incidents...Witnesses listed above confirmed the reported behaviors."

b. During an interview on 2/27/23 at 2:55 PM CNA #2 stated on 1/25/23 she and CNA #1 were with the resident while the resident was in bed. She stated the resident was agitated and "tried to take a swing at" CNA #1 while they were trying to roll the resident in bed. She stated CNA #1 then "shoved [the resident] and [s/he] smacked up against the side rail." She further stated the CNA then called the resident an "asshole."

c. Interview on 2/27/23 at 3:12 PM with EVS supervisor #1 revealed in January 2023 (she was unsure of exact date) CNA #1 and CNA #3 were in resident #1's room providing care to him/her. She was cleaning the resident's bathroom. She stated she overhead the resident say "ow. ow...why do I deserve this?" She stated CNA #1 then said "because you are a dick." She stated at the time of the incident she didn't know the name of the CNA, but she described her to another employee who identified CNA #1. She stated she didn't observe the incident, but overheard it from the bathroom. She stated she thought it was CNA#1 who said that to the resident and not CNA #3 because when she left the bathroom she saw it was CNA #1 who was touching the resident and not CNA #3.

d. Interview on 2/27/23 at 4:13 PM with CNA

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#3 revealed she had witnessed CNA #1 call the resident names. She stated in January 2023 (unsure of exact date) she was working with CNA #1 and the housekeeper (EVS supervisor #1) was in the bathroom and overheard. She thinks CNA #1 called the resident a "dick." She stated she thinks CNA #1 was burned out and was frustrated working with the resident because s/he is "the hardest resident we have." She stated she has only witnessed verbal abuse by CNA #1 and never physical abuse.

e. Interview on 2/27/23 at 4:45 PM with LPN #1 revealed in January 2023 CNA #2 reported that CNA #1 was "rough and abusive" with the resident and had "slammed" the resident into the side rail. She stated she told the CNA to report it to [the NHA]. She stated she checked on the resident and the resident did not have injuries. She stated CNA#1 is "mouthy" and she has witnessed CNA #1 curse about residents behind their backs, but not their faces.

f. Interview on 2/28/23 at 9:09 AM with the resident revealed staff treated him/her "real well". The resident denied any staff member had yelled at him/her, called him/her names, or was rough.

g. During an interview on 2/28/23 at 9:22 AM regarding the allegations CNA #1 stated it was "hard this last year" and "...if they start calling me names, I call them names". She stated resident #1 was hard to work with because s/he is verbally abusive to staff. Regarding the two specific allegations, she stated she does not recall calling the resident names. She also stated she was trying to roll the resident in bed and "I did push forward...I apologized for it...[s/he] hit [his/her] head on the side rail." When asked if she had ever cursed at the resident, she stated "I'm sure I have. I have cursed at [him/her] if [s/he] cursed at me."

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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: Based on review of facility policies and facility documentation, and staff interview, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act for 2 of 2 allegations of abuse reviewed. The findings were:	F 609	F609 □ Immediate training and education provided to CNA #2, LPN #1, and CNA #3 following notification of complaint regarding mandatory timely reporting. All residents identified of being at risk of harm due to untimely reporting.	3/31/23

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F 609	Continued From page 5 1. Review of the facility's policy "Long Term Care Department Abuse, Neglect and Exploitation of Residents and Property" approved 11/17/2022 showed "...Any person who suspects that abuse, neglect or misappropriation of property may have occurred, will immediately report the alleged violation to the facility Director of Nursing." Review of the facility's documentation "Human Resources Fact Finding Summary" showed two allegations of abuse were reported on 1/30/23 involving CNA #1 and resident #1. The following concerns were identified: a. Further review of the "Human Resources Fact Finding Summary" showed for allegation #1, CNA #2 reported the incident happened on 1/25/23. Further review showed the CNA stated she didn't come to the NHA (who was the DON at the time) the day it happened "because State was here. I turned it in to [LPN #1], the charge nurse right after it happened. I was trying to give [NHA] a little bit of space as she was dealing with enough." b. During an interview on 2/27/23 at 4:45 PM LPN #1 stated she did not report the allegation involving CNA #1 to the NHA [who was the DON at that time] because "I spaced it...State was here." c. Review of the facility's documentation "Human Resources Fact Finding Summary" showed for allegation #2, environmental services (EVS) supervisor #1 reported an allegation that she thought occurred on 1/11/23. The documentation showed she stated "I didn't know who to report it to." d. During an interview on 2/27/23 at 3:12 PM EVS supervisor #1 stated she didn't immediately report it because she waited to talk to the housekeeper who normally cleaned the nursing	F 609	All staff from all departments that work in or are exposed to nursing center or nursing center residents will be provided with abuse and neglect training including signs of abuse and neglect and importance of timely reporting and who to report to by March 17, 2023. Annual audit will be performed by administrator to ensure annual abuse and neglect education is provided for each department that works in or is exposed to nursing center or nursing center residents. Quality assurance director will complete a daily audit of occurrence and incidence reports from incidents occurring withing the previous 24 hours to ensure timely reporting. Audit will be reviewed by QAPI committee to identify trends or concerns.	

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F 609	Continued From page 6 home after she returned from her days off. e. On 2/27/23 at 4:13 PM CNA #3, who witnessed allegation #2, stated "I probably should have reported it...I wasn't thinking at the moment." f. On 2/28/23 at 8:16 AM the NHA confirmed staff did not report the allegations timely.	F 609		