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 _____	R-C 04/13/2023

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 revisit survey was conducted on 4/10/23 through 4/13/23 for all previous deficiencies cited on 2/28/23. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set NHA- Nursing Home Administrator 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 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, staff and	{F 600}	Resident #1 interviewed following	5/1/23

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

Electronically Signed | 04/26/2023

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{F 600}	Continued From page 1 resident interviews, and review of personnel files and 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 2/7/23 quarterly MDS assessment showed resident #1 had diagnoses including cerebrovascular accident, transient ischemic attack or stroke, and depression. The assessment showed the resident had a BIMS score of 2 out of 15, which indicated severe cognitive impairment. The following concerns were identified: a. Review of the facility's "Human Resources Fact Finding Summary" showed on 3/16/23 CNA #1 reported that on 3/15/23 she heard CNA #2 say to the resident "You hit me and I'll be the last person you ever hit." Review of the facility's conclusion of their investigation into the allegation showed "[CNA #2] admitted to verbally abusing the patient, losing her temper, and getting a little out of control..." The report recommended that the CNA be terminated from employment for violation of the facility's abuse policy. Review of documentation in the personnel file of CNA #2 dated 3/20/23 showed the facility terminated her employment. b. During an interview on 4/10/23 at 2:09 PM CNA #1 stated on 3/15/23 around 8:40 PM to 10 PM she was working with CNA #2 in the resident's room. She stated the resident was frustrated while the CNAs were assisting him/her with cleaning him/her up in bed. She stated she went into the bathroom to get more wipes and heard CNA #2 say to the resident "You hit me and I'll be the last person you hit." She stated the CNA did not say it in a joking manner, and she was	{F 600}	incident and denies any concerns related to incident. Physical assessment performed following incident and no physical injury identified. Behavior monitoring completed following incident with no identified behavior changes. CNA #2 immediately placed on administrative leave and following investigation, terminated from facility. All other residents identified to be at risk for abuse from CNA #2. Follow up interviews completed with multiple other residents and no other concerns identified. All staff from all departments that work in or are exposed to nursing center or nursing center residents will be provided with additional training regarding abuse reporting and what is abuse by May 1, 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 unsure what the resident's response was because she wasn't looking at the resident. She further stated the resident and CNA #2 "bickered back and forth" and so she told both of them to "calm down...take a breath." She stated after the incident she reported the incident to the charge nurse, RN #1, and then also reported it the following day. c. On 4/10/23 at 3:07 PM the resident was interviewed. He did not recall the incident and had no concerns with staff. d. During a phone interview on 4/10/23 at 3:28 PM RN #1 stated CNA #1 did report to her that CNA #2 told resident #1 something like "don't hit me...I'll be the last person you hit" the evening of 3/15/23. e. On 4/10/23 at 3:34 PM CNA #2 was interviewed via phone. She stated on the evening of 3/15/23 she and CNA #1 were assisting the resident in bed. She stated the resident was agitated and was cussed at her. She stated the resident then doubled up his/her fist and started swinging. She stated she told the resident "If you hit me, it will be the last time you will hit a woman." She stated she should not have said that and she didn't mean it.	{F 600}		
{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	{F 609}		5/1/23

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{F 609}	Continued From page 3 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, investigations, and incident reports, 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 1 of 1 allegation of abuse reviewed (#1). The findings were: 1. Review of the facility's "Human Resources Fact Finding Summary" showed CNA #1 reported that on 3/15/23 she heard CNA #2 say to the resident "You hit me and I'll be the last person you ever hit." The following concerns were identified: a. Further review of the "Human Resources Fact Finding Summary" showed the allegation wasn't reported until 3/16/23. b. Review of the facility's incident report	{F 609}	Following incident, training provided to CNA #1 and RN#1 regarding mandatory timely reporting to DON or administrator. All residents identified of being at risk of harm due to untimely reporting. All staff from all departments that work in or are exposed to nursing center residents will be provided with addition abuse training including what is abuse and timely reporting by May 1, 2023. Quality assurance director will complete a daily audit of abuse occurrences and timely reporting within 2 hours of incident occurrence. Audit will be reviewed by QAPI committee to identify trends and concerns.	

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{F 609}	Continued From page 4	{F 609}		

submitted to the State Survey Agency showed the alleged incident occurred on 3/15/23 but was not reported to the administrator or the State Survey Agency until 3/16/23 at 10:45 AM and 12 PM respectively.

c. During an interview on 4/10/23 at 2:09 PM CNA #1 stated on 3/15/23 around 8:40 PM to 10 PM she and CNA #2 were in the room of resident #1. She stated the resident was frustrated while the CNAs were assisting him/her with cleaning him/her up in bed. She stated she went into the bathroom to get more wipes and heard CNA #2 say to the resident "You hit me and I'll be the last person you hit." She stated after the incident she reported it to the charge nurse, RN #1, and then also reported it the following day.

d. On 4/10/23 at 2:38 PM the NHA revealed the incident from 3/15/23 was reported to her on 3/16/23. She stated the initial reporting from staff was late, but she reported it to the State Survey Agency within 2 hours of her finding out about the incident.

e. During a phone interview on 4/10/23 at 3:28 PM RN #1 stated CNA #1 did report to her on 3/15/23 that CNA #2 told the resident something like "don't hit me...I'll be the last person you hit." She stated she did not report it to the DON or NHA because she didn't think it was abuse, but rather that the CNA was frustrated.

f. On 4/10/23 at 3:34 PM CNA #2 was interviewed via phone. She stated on the evening of 3/15/23 she and CNA #1 were assisting the resident in bed. She stated the resident was agitated and cussed at her. She stated the resident then doubled up his/her fist and started swinging. She stated she said "If you hit me, it will be the last time you will hit a woman." She stated she should not have said that and she didn't mean it.

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{F 609}	Continued From page 5 g. Review of the facility's Long Term Care Department policy "Abuse, Neglect, and Exploitation of Residents and Property" (undated) showed..."Any person who suspects abuse, neglect, or misappropriation of property may have occurred, will immediately report the alleged violation to the charge nurse...Charge nurse will report to the Director of Nursing of Nursing Home Administrator...Charge Nurse will notify State Survey Agency of any potential abuse within 2 hours..." On 4/10/23 at 2:34 PM the NHA stated the date of the policy was 3/1/23.	{F 609}		