STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK	**1445 UINTA DRIVE GREEN RIVER, WY 82935**

(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 from 11/28/23 through 11/29/23. The survey was prompted by complaint intake WY00003723.	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, policy review, staff 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 2 sample residents (#1) reviewed for abuse allegations. The findings were: 1. Review of the admission minimum data set (MDS) assessment dated 9/10/23 showed resident #1 had the ability to understand others, had diagnoses including cancer, and had a brief interview for mental status (BIMS) score of 8 out of 15, which indicated moderately impaired	F 600	Abuse and Reporting education was done will 100% of Mission employees; completed by December 8th 2023. Angel Rounds have been initiated to continue random screening and follow up of residents to ensure safety, support and well being. All residents have the potential to be affected. Weekly angel rounds will continue to be	12/29/23

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

Electronically Signed | 12/19/2023

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F 600	Continued From page 1 cognition. Review of progress notes showed the resident passed away on 9/30/23. The following concerns were identified: a. Review of facility investigation documentation showed a registered nurse (RN) reported that certified nurse aide (CNA) #1 told a resident "[resident name], if you don't stop screaming, I'm going to strangle you." This was reported on 11/1/23 to the director of nursing (DON). The documentation showed that the CNA admitted to saying that to the resident. The documentation showed during the facility's investigation it was discovered the CNA was mocking, mimicking, and antagonizing residents, and making them feel unsafe and uncomfortable. The facility substantiated abuse and terminated the employment of the CNA. b. The resident was unable to be interviewed because s/he passed away. c. During an interview on 11/28/23 at 2:18 PM maintenance staff #1 stated he heard CNA #1 tell another resident (#2) to "shut up" and "stop being so loud." He stated this occurred around September 26th or 27th. He stated he wouldn't want anybody to talk to his Grandmother that way. d. On 11/28/23 at 2:25 PM the DON, administrator, and social services director were interviewed. They stated RN #1 reported that she heard CNA #1 tell resident #1 if s/he didn't shut his/her mouth, he would strangle him/her. They stated they were unable to interview the resident because s/he had passed away. They stated the CNA admitted to saying it and they substantiated abuse. e. On 11/28/23 at 3:19 PM RN #1 stated she reported concerns about CNA #1 to the DON during a conversation. She stated she heard the CNA tell resident #1 "if you don't stop screaming	F 600	done to confirm freedom from abuse. The Social Services Director and or designee will be responsible for for follow up of angel rounds and ensure that proper procedures are followed. Education was completed with all employees. The employee in question was termed immediately. A monthly audit of completed Angel Rounds will be done by Director of Nursing and or designee. All findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations to reduce audits based on compliance and success of education. The Director of Nursing is responsible for the compliance of this tag and reporting.	

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F 600	Continued From page 2	F 600		

I will strangle you." She was unsure of the exact date, but stated it was toward the end of the resident's stay, so around the end of September. She stated the resident was on hospice, was declining, and due to his/her cognition, would have been unable to report concerns on his/her own. When asked how the resident reacted to what the CNA said, she stated the resident responded "Why?"

f. During an interview on 11/28/23 at 3:26 PM CNA #1 admitted to the allegation. He stated "I said some things I shouldn't have." He stated he told the resident "If you don't be quiet, I'm going to strangle you." When asked why he said that, he replied "Don't know why. It slipped out." He stated throughout the night the resident was calling out.

g. On 11/28/23 at 3:46 PM CNA #2 stated she was interviewed as part of the investigation. She stated she didn't like the way CNA #1 talked to residents. She stated he would cuss at them and was not respectful. She stated he antagonized resident #2 and would "mock" other residents.

h. During an interview on 11/28/23 at 7:08 PM CNA #3 stated CNA #1 would mock residents and call them inappropriate names. When asked for an example, she stated he would make fun of their names.

i. During a follow-up interview on 11/29/23 at 9:17 AM, RN #1 stated when she heard CNA #1 say he would strangle resident #1, she thought it was inappropriate, but didn't think he would actually carry through with what he said. She stated due to the resident's cognition, the resident would have been unable to voice how it made him/her feel. When asked how cognitive residents might feel if the CNA said that to them, she replied "Many would be offended, and might think he would follow through with actions."

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F 600	Continued From page 3 j. On 11/29/23 at 9:29 AM the social services director and administrator were interviewed again. They stated they thought the CNA was immature and said something inappropriate, but didn't think he had malicious intent. The stated they would normally interview the resident during an investigation, but they were unable to interview resident #1 because s/he passed away. When asked how other residents might have reacted to the CNA saying that to them, they stated some residents might have thought he was joking, but others might not have. k. Review of the facility's "Abuse Prohibition" policies (undated) provided by the administrator on 11/28/23 at 1:29 PM showed "...Each resident living in this Community has the right to be free from abuse, neglect and misappropriation of their property...For the purposes of this policy, the following definitions will apply:..."Verbal Abuse" is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: threats of harm; making statements to frighten a resident, such as telling a resident that he/she will never be able to see their family again."	F 600		