STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE COUNTY HEALTH	333 N BRIDGER AVE PINEDALE, WY 82941

(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 Survey from 4/16/24 to 4/17/24. The survey was prompted by complaint intake WY000003845. The following common abbreviations are used throughout this document: CNA: Certified Nurse Assistant DON: Director of Nursing 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 observation, medical record review, resident and staff interviews, review of the facility's investigation, state survey agency incident database review, and policy and	F 600	483.12: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.	5/28/24

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

Electronically Signed | 05/08/2024

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F 600	Continued From page 1 procedure review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 1 (#2) sample residents reviewed for abuse allegations. The findings were: 1. Review of the medical record for resident #2 showed an admission date of 12/22/19 and diagnoses which included hemiplegia/hemiparesis affecting the right/dominant side of the body. Further review showed the resident received comfort care to manage symptoms and the resident's prognosis was poor for recovery. Observation on 4/17/24 at 10 AM showed the resident was resting comfortably in bed with family at the bedside. Observation at that time showed the resident appeared thin and frail but was able to open his/her eyes and answer yes/no questions. Interview with the resident at that time, revealed the resident was comfortable, felt safe, and had no complaints related to care. The following concerns were identified. a. Review of the state survey agency incident database showed the facility reported an incident on 3/25/24 which involved resident #2 and CNA #3. The incident alleged CNA #3 was providing incontinence care to resident #2 and said "you are the most disgusting [woman/man] ever, why would you do this. This is disgusting. What kind of person does this?" Further review showed the CNA admitted her comments were "unprofessional" and she "deserved whatever punishment you see fit." b. Interview with the administrator on 4/17/24 at 10:25 AM confirmed an allegation of verbal abuse towards resident #2 on 3/20/24 and was reported to administration on 3/25/24. She verified an internal investigation was started	F 600	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. The facility failed to meet the requirement as follows: On 03/25/2024, resident #2 was resting in bed when CNA #3 was providing incontinence care to resident #2 and said "you are the most disgusting [woman/man] ever, why would you do this. This is disgusting. What kind of person does this?" To correct deficient practice, the facility: 1. To ensure immediate safety of the resident: DON reported the incident upon DON immediately upon notification. 1a. Staff member in question was immediately discharged from facility until investigation concluded with staff in question was terminated. 2. To ensure safety of all residents, social services conducted an audit of one-third of residents & staff to ensure no other abuse had occurred and that residents felt treated with respect. No other issues were noted. 3. Staff were provided education immediately regarding recognizing and reporting abuse, with further training scheduled All Staff for 5.28.24 to provide further education/ review abuse, neglect	

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F 600	Continued From page 2 immediately after notification and the facility substantiated the allegation of verbal abuse towards resident #2 by CNA #3. Further interview revealed the facility notified the proper authorities and terminated the CNA. c. Interview with CNA #1 on 4/17/24 at 11:55 AM revealed the aide witnessed verbal abuse towards resident #2 by CNA #3 on the evening of 3/20/24. The incident "disturbed" the CNA and it was reported to the nurse on duty that evening; however, it was not reported to administration until 3/25/24. CNA #1 stated she was new to the facility and at the time was not familiar with the procedure for reporting abuse allegations to administration. d. Review of the statement provided by CNA #3 dated 3/26/24 showed an acknowledgement of unprofessional behavior towards resident #2 on 3/20/24 after an episode of incontinence. e. Review of the statement provided by CNA #2 dated 3/26/24 showed on the night of 3/20/24 resident #2 had an incontinence accident in the bed and CNA #3 was heard calling the resident "a disgusting [woman/man]" while assisting the resident with care. 2. Review of the resident's rights, no date, showed "It is the goal of our facility to promote and protect the rights of each resident...26. The right to be free from physical, psychological, or sexual abuse or punishment..." 3. Review of the facility policy "Abuse, neglect, mistreatment of residents" dated 12/2023, showed 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 hearing distance, regardless of their age, ability to	F 600	and recognizing risk factors for self and residents and potential abuse. 4. Audits will continue to be conducted by Social Services to ensure residents continue to feel respected and well treated. 5. DON will report on staff interactions, Social Services will report on audit/resident interview results as a function of QAPI.	

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F 600	Continued From page 3 comprehend, or disability...g. Reasonable Person Concept: A person with an ordinary degree of reason, foresight or intelligence, whose expectation in relation to a particular circumstance is used as an objective standard by which to measure or determine something. In other words, a resident who has mental incapacity/dementia who is victim of abuse may not show a reaction, however, a reasonable person could experience harm related to the abuse, which would be applied in these situations."	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 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	F 609		5/28/24

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F 609	Continued From page 4 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 the facility's incident log, staff interviews, state survey agency incident database review, and policy and procedure review, the facility failed to report all alleged violations of abuse immediately after the occurrence for 1 of 1 sample residents (#2). The findings were: 1. Review of the facility incident log showed an allegation of verbal abuse of a resident during the month of March, 2024. 2. Review of the state survey agency incident database showed an allegation of verbal abuse was reported on 3/25/24; however, the incident occurred on 3/20/24 at 10:20 PM, 5 days before it was reported. 3. Interview with the administrator on 4/17/24 at 10:25 AM confirmed an allegation of verbal abuse towards resident #2 occurred on 3/20/24 and was reported to administration on 3/25/24. 3. Interview with CNA #1 on 4/17/24 at 11:55 AM revealed the aide witnessed verbal abuse towards resident #2 by CNA #3 on the evening of 3/20/24. The incident "disturbed" the CNA and it was reported to the nurse on duty that evening but not reported to administration until 3/25/24. CNA #1 stated she was new to the facility and at the time was not familiar with the procedure for reporting abuse allegations to administration.	F 609	483.12:response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 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. The facility failed to meet the requirement as follows: Review of the state survey agency incident database showed an allegation of verbal abuse was reported on 3/25/24; however, the incident occurred on 3/20/24 at 10:20 PM, 5 days before it was reported. To correct the deficient practice, the facility acted as follows:	

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F 609	Continued From page 5 5. Review of the facility policy "Abuse, neglect, mistreatment of residents..." dated 12/2023 showed, "any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect...shall immediately report to the Director of Nursing or the Nursing Home Administrator..."	F 609	1. Education of staff directly involved regarding facility practice. 2. To ensure safety of all residents, social services conducted an audit of one-third of residents & staff to ensure no other abuse had occurred and that residents felt treated with respect. No other issues were noted. 3. Audits will continue to be conducted by Social Services to ensure residents continue to feel respected and well treated. All future grievances will be monitored for timeliness of reporting & reported as a function of QAPI by DON. 4. All staff education to occur 5/28/24. 5. DON will report on staff interactions, Social Services will report on audit/resident interview results as a function of QAPI.	