STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Evanston	475 Yellow Creek Road Evanston, WY 82930

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on medical record review, resident and staff interview, facility incident review, and policy and procedure review, the facility failed to protect the residents' right to be free from verbal abuse by a staff member for 1 of 6 sample residents (#4). This failure resulted in actual psychosocial harm to resident #4. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 9/5/24. 1. Review of the quarterly Minimum Data Set assessment dated [DATE] showed resident #4 had a brief interview for mental status score of 9 out 15, which indicated moderate cognitive impairment, and diagnoses which included cerebrovascular accident, hemiplegia or hemiparesis, and depression. Further review showed the resident did not exhibit physical or verbal behavioral symptoms or rejection of care. The following concerns were identified: a. Review of an incident report dated 8/31/24 showed CNA #1 and CNA #2 were assisting the resident with care. The resident called CNA #1 a bitch and told the CNA to get out of his/her room while using expletives. The CNA responded by calling the resident a cunt. The incident was reported by CNA #2 to the nurse and the nurse notified administration. CNA #1 was placed on suspension pending an investigation. During the investigation, resident #4, who has difficulty with communication, reported CNA #1 was making fun of him/her, grabbed [him/her] and told the resident to knock it off, and s/he totally lost her mind. The resident was emotional during the interview, said CNA #2 was good and nice, and acknowledged s/he had been swearing, yelling, or using foul language with staff that day. The investigation showed resident #4's representative reported the resident had called after the incident to report CNA #1 was mocking the resident due to his/her difficulty speaking and the resident was embarrassed and belittled. The resident's representative reported CNA #1 had been one of the resident's favorites in the past. The Investigation showed CNA #2 reported the resident had been cursing at staff and CNA #1 called the resident a F-ing Cunt and may have been a bit rough. CNA #2 described the resident as a bit stunned after the incident. Further review showed CNA #1 admitted to calling the resident the name and was terminated from the facility. b. Interview with resident #4 on 9/17/24 at 5:24 PM revealed the CNA #1 entered the room and was speaking to him/her in a way s/he felt was making fun of him/her. CNA #1 forced the resident to roll over in bed and it made the resident mad. Following the incident, the resident revealed s/he called his/her daughter while crying, because s/he was upset. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	c. Interview with CNA #2 on 9/18/24 at 9:21 AM revealed on the day of the incident, she had asked CNA #1 to assist with providing care to the resident. She revealed CNA #1 forcefully repositioned the resident and the resident called the CNA a fucking bitch and CNA #1 responded by calling the resident a fucking cunt. Further interview revealed CNA #1probably made fun of resident #4 during the incident; however, she does not recall it. d. Attempted interview with CNA #1 on 9/18/24 at 9:15 AM was unsuccessful. A message was left and no return call was received. e. Interview with the administrator on 9/18/24 at 10:45 AM confirmed CNA #1 was terminated from the facility. The administrator revealed although the resident curses often, s/he did not normally get upset which made the facility believe the resident was affected by the incident. The administrator revealed resident #4 had previously refused counseling services offered by the facility; however, s/he accepted counseling following the incident. Further interview revealed as a result of the incident, the facility completed abuse training for staff, interviewed residents, performed ongoing customer satisfaction surveys, and were reviewing abuse in during their quality assurance meeting. f. Interview with licensed clinical social worker #1 on 9/18/24 at 11:05 AM confirmed resident #4 began counseling services and the incident was an area to address. g. Review of the facility policy titled Abuse, Neglect, and Exploitation last revised 6/2023 showed .1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of resident and misappropriation of resident property . 2. The following plan of correction was implemented by the facility on 9/5/24: a. CNA #1 was terminated from the facility. b. Residents were interviewed related to abuse and neglect. c. Counseling services were offered, accepted, and implemented with resident #4. d. Staff completed training related to the Dos and dont's of managing a client who is angry or aggressive and Techniques for managing cognitive impairment. e. Customer Satisfaction Surveys. f. Quality Assurance review of abuse.