STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

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** Based on observation, staff and resident interview, review of facility investigation information, and medical record review, the facility failed to ensure 1 of 4 sample residents (#1) reviewed for abuse was kept free from abuse. The findings were: Review of the 1/27/20 quarterly MDS assessment showed resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The resident required the total assistance of staff for ADLs including bed mobility, transfers, toileting, eating, personal hygiene, and bathing. According to the assessment the resident had no delusions or hallucinations, had no verbal or physical behavioral symptoms, and did not reject care. Review of the 5/4/20 timed at 10:27 AM, and the 5/11/20 timed at 10:26 AM weekly progress notes showed the resident was able to make his/her wants and needs known by using yes/no questioning and picture communication boards, and was able to use the call light when needing assistance. The following concerns were identified: 1. Review of the facility investigation report dated 5/6/20 at 11:39 AM showed the resident suffered an injury to the left eye and alleged someone had hit him/her. During the un-timed interview with the resident conducted by the facility on 5/5/20 the resident revealed CNA #7 had hit him/her. Further review showed an un-dated and un-timed written statement by RN #3. The statement showed when asked what happened to cause the skin tear and bruise to his/her left eye, the resident put his/her hand up and said to her and CNA #6 who was in the room, hit me. The statement showed the RN asked someone hit you? The resident stated yes, hit me and man, mean one. CNA #6 went to get the DON to come to the resident's room at that time to hear the allegation. An un-dated and un-timed written statement from CNA #6 showed she agreed with the statement made by RN #3. 2. Review of the nurse's note dated 5/5/20 timed at 3:34 AM showed RN #1 documented she was called into the resident's room by another staff member and reported the resident had blood in his/her eyes. Upon assessment she noted skin tear in 2 places measuring about 0.4 cm to the left eyebrow. Elder was unable to say how (s/he) sustained the injury. 3. Interview with RN #1 on 5/14/20 at 6:36 AM revealed CNA #1 called her to come to the resident's room. The resident had a small cut on the left eyebrow and the RN cleaned and dressed the area. The RN stated she didn't understand the resident and was not sure how the injury occurred. She suspected the resident may have contacted the call light clip, causing the injury. She called the on-duty staff into the room to try and determine what happened. The RN stated there was one thing that didn't make too much sense: when (CNA #7) walked in, the resident pointed to the CNA. 4. Interview with CNA #1 on 5/14/20 at 6:50 AM revealed she had responded to the resident's call light and saw blood on the resident's left eye, and the resident said hit me. The CNA used her radio to call for the nurse and she stayed with the resident. RN #1 came in and cleaned the blood and dressed the wound. The CNA stated she told the nurse what was said and at one point when the resident stated hit me she asked who hit you? The resident said him and was referring to CNA #7 who had come into the room. The CNA also stated she picked up the call light and asked did this hit you? The resident responded yes. The interview with the CNA further revealed the facility had not interviewed her about the incident. 5. Interview with CNA #7 on 5/14/20 at 9:40 AM revealed he took care of the resident during the early morning of 5/5/20 and recalled he provided oral care and changed the resident around 2:40 AM. The CNA stated there was no injury to the resident during these cares. The CNA stated after leaving the resident's room he responded to a call light on the other hallway, and when coming out of that room, talked to CNA #3 in the hallway. He stated CNA #3 told him she had just been into resident #1's room to change him/her. CNA #7 then stated he overheard on the radio CNA #1 calling the nurse to resident #1's room so he went to the room. There was blood on the resident's face and (the resident) pointed at me when I came in. The CNA further stated the resident said mean man so I left the room thinking that would be best. The CNA stated he completed his shift which ended at 6:30 AM. He was unavailable when the facility attempted to call him on 5/5/20, but went in on 5/6/20 for a meeting where he was asked to make a statement and was suspended pending an investigation. The CNA denied any knowledge of how the injury to the resident occurred. He was not sure why the resident said mean man. 6. Interview with CNA #3 on 5/14/20 at 4:27 PM revealed she worked the early morning of 5/5/20 and was aware there had been an injury to resident #1. The CNA stated she covered the hall when the assigned aide (CNA #1) was on break. She remembered going in to answer the resident's call light before her break and she unwrapped the call light cord from the resident's leg, because s/he had gotten tangled up in it. She stated there was no injury to the resident at that time. The CNA stated the resident was known to be obsessed with the call light and the resident called frequently. She clipped the call light to a pad that was on the wall by the head of the resident's bed. This is where the light was usually clipped and the resident could reach it. CNA #3 denied talking with CNA #7 about changing the resident that morning. She also denied being in the resident's room after her break. She did not witness any injury when she answered the call light and had not heard the resident say someone hit him/her. 7. Interview with the resident on 5/12/20 at 4:25 PM with the social services specialist also in attendance revealed the resident could answer yes/no questions using a communication board. The resident pointed to the word yes or no when asked a question. The resident at times attempted to speak but was not understood. The resident responded yes when asked if a staff member hit him/her and responded yes to the facility knowing about the incident. When asked if there was an injury related to being hit, the resident responded yes and pointed to the healing area above the left eye. Observation at that time showed some redness to the area. The resident confirmed it was CNA #7 who had hit him/her. The resident also responded no when asked if the staff member still worked at the facility. The resident responded yes to feeling okay about the current situation with his/her care. 8. Further review of the facility investigation information showed video surveillance was reviewed for the morning of 5/5/20 from midnight to 3:47 AM. The surveillance showed staff entering and exiting the resident's room. The surveillance showed CNA #7 was the last person in the resident's room prior to the injury being identified. The following was recorded: a. CNA #3 in at 2:27 AM to 2:29 AM. b. CNA #7 in at 2:37 AM to 2:44 AM. c. CNA #1 in at 2:54 AM to 3:21 AM (This is when the injury was identified.) d. RN #1 in at 2:55 AM to 3:04 AM. e. CNA #7 in at 2:55 AM to 2:56 AM. f. CNA #7 in at 3:00 AM to 3:01 AM. g. RN #1 in at 3:05 AM to 3:11 AM. h. RN #1 in at 3:12 AM to 3:21 AM. i. RN #1, CNA #1, CNA #3, and CNA #7 in at 3:42 AM to 3:47 AM. 9. Interview with the DON and the social services specialist on 5/12/20 at 5:30 PM revealed they began an investigation on the day shift of 5/5/20 when they learned about the injury and allegation. The DON stated she and the social services specialist used a picture communication board to interview the resident. The resident reported being hit which caused the injury to his/her left eye. With the picture board the resident was able to identify the perpetrator as a male staff member who wore glasses, and this was consistent with CNA #7. After a meeting with CNA #7 on 5/6/20 at 10 AM the CNA completed a written statement and his employment was terminated that day. The DON felt there were inconsistencies in the CNA's statement in relation to the video surveillance. She stated I suspect (the resident) is telling the truth but can't prove it.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, resident and staff interview, review of facility investigation information, and review of policy and procedure, the facility failed to ensure resident protection following an allegation of abuse, and failed to ensure a thorough investigation was completed for 1 of 3 investigations reviewed (incident involving resident #1 on 5/5/20). The findings were: 1. Review of the facility incident report dated 5/6/20 showed resident #1 had what the facility reported as an injury of unknown origin, discovered on 5/5/20 at approximately 2:55 AM, and the resident made an allegation of abuse against a staff member. The resident had sustained an injury to his/her eye, a cut and bruise, which s/he alleged was caused when a staff member hit him/her. Review of the 1/27/20 quarterly MDS assessment showed the resident had [DIAGNOSES REDACTED]. The resident required the total assistance of staff for ADLs including bed mobility, transfers, toileting, eating and personal hygiene and bathing. According to the assessment the resident had no delusions or hallucinations, and had no behavioral symptoms. Review of the 5/4/20 timed at 10:27 AM, and the 5/11/20 timed at 10:26 AM weekly progress notes showed the resident was able to make his/her wants and needs known by using yes/no questioning and picture communication boards, and was able to use the call light when needing assistance. Interview with the resident on 5/12/20 at 4:25 PM with the social services specialist also in attendance revealed s/he could answer yes/no questions using a communication board. The resident pointed to the word yes or no when asked a question. The resident at times attempted to speak but was not understood. The resident responded yes when asked if a staff member hit him/her and responded yes to the facility knowing about the incident. When asked if there was an injury related to being hit, the resident responded yes and pointed to the healing area above his/her left eye. Observation at that time showed some redness to the area. The resident confirmed yes it was CNA #7 who had hit him/her. The following concerns were identified: a. Interview with CNA #7 on 5/14/20 at 9:40 AM revealed he worked out his shift the morning of the allegation. His shift ended at 6:30 AM. He later met with the facility administration and was suspended and ultimately terminated. b. Review of the facility investigation showed other than resident #1 and the roommate, there were no additional residents interviewed related to the staff member who was alleged to be abusive. c. Interview with CNA #1 on 5/14/20 at 6:50 AM revealed she had responded to the resident's call light the morning of 5/5/20 and saw blood on his/her left eye, and the resident said hit me. The CNA used her radio to call for the nurse and she stayed with the resident. RN #1 came in and cleaned the blood and dressed the wound. The CNA stated she told the nurse what was said and at one point when the resident stated hit me she asked who hit you? The resident said him and was referring to CNA #7, who had come to the room. The CNA also stated she picked up the call light and asked did this hit you? The resident responded yes. The interview with the CNA further revealed the facility had not interviewed her about the incident. d. Interview with the DON and the social services specialist on 5/12/20 at 5:30 PM revealed they began an investigation on the day shift of 5/5/20 when they learned about the injury and allegation. Review of the investigation showed it lacked times documented for the interviews. The DON stated she and the social services specialist used a picture communication board to interview the resident. Through this communication, the resident reported being hit which caused the injury to his/her left eye. With the picture board the resident was able to identify the perpetrator as a male staff member who wore glasses, and this was consistent with CNA #7. After a meeting with CNA #7 on 5/6/20 at 10 AM the CNA completed a written statement and was terminated that day. The DON felt there were inconsistencies in the CNAs statement with relation to the video surveillance. She stated I suspect (the resident) is telling the truth but can't prove it. The DON also verified other than the roommate of resident #1, no other residents were interviewed related to the investigation. The roommate denied seeing or hearing anything. Additionally, the DON reported she had not completed a state required report with the CNA's information because she was focused on the resident being an injury of unknown origin. A later interview on 5/14/20 at 11:23 AM with the DON further revealed the incident was not reported to the police. e. Interview with the administrator on 5/13/20 at 11:40 AM confirmed the police were not notified of the allegation of abuse. She stated the investigation focus was an injury of unknown origin, and they felt they lacked evidence to substantiate abuse, so it was not determined necessary to contact the police. 2. Review of the Abuse prevention policy and procedure titled Abuse/Neglect/Misappropriation/Exploitation with a review date of 8/28/18 showed . in the event of an allegation of abuse, the named employee will be suspended without pay, while the Administrator, Director of Nursing and/or Social Services (or designee) conduct an in-depth, documented investigation into all charges .the reporting of alleged abuse, exploitation, and/or neglect will be done according to state and federal guidelines .