Reviewed & approved 0945 AM 8/28/14 [illegible]
Notified DON d/t NHA OOF [illegible]

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Healthcare Licensing and Surveys

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING ______ B. WING ______	C 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

(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 The following common abbreviations are used throughout this document: DON - Director of Nursing LPN - Licensed Practical Nurse CNA - Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of the deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of resident council minutes and the grievance procedure, the facility failed to operationalize a coordinated process to address residents' concerns. The findings were: Interview with the director of social services on 6/30/14 at 2:20 PM revealed that depending on the specific issue, the residents should discuss their concerns with either nursing or social services. During an interview on 7/1/14 at 11:15 AM, the director of social services revealed there were complaint forms near her office that were available for residents and/or families if they had a concern. Review of the facility's Grievance Procedure showed "Oral or written grievance/complaints may be submitted to the	F 166	1. All residents and family complaints will be addressed in a timely manner and all resolutions will be documented. 2. All residents and interested family members are affected. All grievances will be addressed and resolved in accordance with corporate policy as well as state and federal regulations. 3. A new grievance policy has been written to operationalize the process for receiving and resolving complaints and grievances. We also revised the publicly posted grievance procedure to current agency addresses and telephone numbers. Management staff were in-serviced on 7/2/14 on how to manage the grievance process and the new policy. All staff were in-serviced on 7/8/14 on how to do grievance and concern intakes. A copy of the revised grievance policy was mailed to all family/representatives on July 10, 2014. ~~We have also addressed the issue~~ with resident council, residents were	7/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE
(X6) DATE: 7/28/14

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 166	Continued From page 1 Social Services Staff member who is designated to handle grievances and recommendations." The following problems were noted: 1. Interview with 11 residents from the resident council on 7/1/14 at 10:30 AM revealed none of the residents knew who to talk with, or what procedure to follow, when they had a concern. The residents said they were not sure if they should contact the ombudsman, the director of nursing, or the director of social services. 2. The residents also stated they had voiced ongoing concerns regarding the menu not being followed as posted, and this problem had not been resolved. Review of the resident council minutes for May and June 2014 verified the residents had expressed concerns regarding the menu items not being served as listed on the menu.	F 166	talked through the process of how this facility will now be filing and handling their grievances. Resident Council signed off on 7/16/14. 4. Administrator will audit all grievances and resident council minutes monthly. Audit results to QA monthly to insure that compliance is maintained.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	Background Checks: 1. The corrective action cannot be implemented as CNA #5 no longer works here. 2. All residents are affected. All new hires will be reviewed in accordance with corporate policy. 3. We have revised our abuse policy further defining employee background screening. We have developed a policy and procedure for criminal background checks that defines fitness determinations for employment. The new policy includes permanent disqualifying convictions and	7/16/14

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F 225	Continued From page 2 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 staff interview, and review of personnel files and incident reports, it was determined the facility failed to complete a thorough screening and follow-up when hiring CNA #5. The facility failed to make reasonable efforts to uncover information about the CNA's prior employment and past court actions. This CNA was alleged to have assaulted a resident in the facility. The findings were: Review of a 6/12/14 incident report sent to the State Survey Agency (SSA) showed CNA #5 was alleged to have assaulted a resident on 6/11/14. Review of the personnel file for this CNA revealed he applied for a position at the facility on 8/22/13.	F 225	disqualifying criminal history. All managers were in-serviced on abuse policy revision, background screening and the new policy on criminal background checks on 7/2/14. All staff were in-serviced on background check requirements on 7/8/14. 3a. The administrator received 2 in-services: 1) Intellicorp Basic User Training on July 3, 2014 by Intellicorp Corporate Training Specialist and 2) Intellicorp Report Analysis and Best Practices Training on July 7, 2014 by Intellicorp Manager of Client Implementations. Certificates of completion on file. 4. All new hires or other reasons for criminal background checks that flag questionable criminal history will be reviewed and signed by the administrator and corporate representative. All new hires will be audited for one year. Audits reported to QA monthly. Abuse Reporting: 1. The failed practice for resident #9 cannot be corrected. The failed practice for the 4/16/14 abuse allegation cannot be corrected. 2. All residents are affected. All abuse allegations will be reported in accordance with state and federal regulations.	

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F 225	Continued From page 3 Review of the 8/23/13 electronic IntelliCorp "Background Report", also in the CNA's personnel file, revealed he had misdemeanor charges of "violation protective order" and "assault on female". The following concerns were identified: a. Interview with LPN #1 on 7/1/14 at 9:15 AM revealed she was responsible for hiring CNA #5 and was aware of the results of his background check at the time of hire. The LPN verified she made no attempt to attain additional factual information regarding the misdemeanor charges. b. Interview with the administrator on 7/1/14 at 4:06 PM revealed he was transitioning into the position of administrator at the time CNA #5 was hired. He said he was also aware of the information on the background check prior to hiring CNA #5. The administrator further stated he accepted the CNA's explanation of the charges without validating the facts. c. Further review of the 8/22/13 application for CNA #5 showed he had been employed on four different occasions as a CNA. However, review of the "Reference Verification" form in his personnel file revealed only one reference check was conducted by the facility prior to hire. Interview with the business office manager on 7/1/14 at 7:40 AM revealed she was responsible for coordinating the hiring process for new employees. The business office manager stated she thought the facility policy was to have three reference checks, or at least two, since the form was designed for two reference checks. Interview with LPN #1 on 7/1/14 at 9:15 AM verified that she had done only one reference check. Based on observation, staff interview, and review of incident reports, fall reports, and medical records, the facility failed to report and to	F 225	3. All management staff were in-serviced on the policy for reporting injuries of unknown origin and abuse reporting requirements on 7/2/14 by corporate staff. Charge Nurses and CNAs were in-serviced on injuries of unknown origin and the reporting process on 7/8/14. Management staff were in-serviced by Adult Protective Services on 7/15/14 on chapter 20 35-20-101 thru 116 of the Adult Protective Services Act. 4. The administrator will audit all abuse reports to insure timely submission. Results of audits will be reported to QA monthly to insure continued compliance for 1 year.	

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F 225	Continued From page 4	F 225		

investigate a suspicious injury of unknown origin for resident (#9) in a timely manner. Finally, the facility failed to report 1 of 1 allegation of neglect according to state law and to report the investigative findings within the required timeframe. The findings were:

1. Observation on 6/30/14 at 11:06 AM revealed there was a bruise and open skin tear on the right arm of resident #9. The bruise was approximately six inches long and circled the resident's forearm. Interview with CNA #1 at the time of the observation revealed she was unsure how the resident sustained the bruise and skin tear but that she had reported it to the nurse. The following concerns were identified:

a. Interview with LPN #2 and the DON on 6/30/14 at 11:27 AM revealed they were unaware of how the resident sustained the injury to the right arm. They said the resident had fallen on 6/21/14 but had sustained no injury from that fall. Review of that fall report also verified there was no injury on 6/21/14. Review of the medical record showed no documentation regarding the bruise and skin tear at the time.

b. Observation with LPN #1 on 7/1/14 at 10:15 AM showed the wound measured 2 1/2 millimeters in length, 0.5 millimeters in width, was moon shaped, and was a yellow green color. The bruise measured 12 millimeters in length and 8 milliliters at it's widest point. Interview with the LPN at the time of the observation revealed she was unsure how the resident sustained the bruise and skin tear. The LPN further verified this resident's injury of unknown origin had not been identified on an incident report and was not investigated. Review of facility incident reports showed no evidence this suspicious injury of unknown origin was investigated or reported to

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F 225	Continued From page 5 the SSA and other agencies as required by state law. 2. On 4/16/14 the facility reported an allegation of resident neglect to the SSA; however, the results of the investigation were not reported to the SSA until 6/20/14 (almost 2 months later). There was also no evidence the allegation was reported to the Department of Family Services or a law enforcement agency as required by state law. Interview with the administrator on 7/1/14 at 4:05 PM verified the allegation had not been reported to other officials in accordance with state law. The administrator further verified the five-day investigative report was late because he was unaware of the requirements for the investigations.	F 225		