Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535051	A. Building B. Wing	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/01/2014	ID Prefix F0278 Reg. # 483.20(g) - (i) LSC	Correction Completed 06/01/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 06/01/2014
ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 06/01/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/01/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 06/01/2014
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/01/2014	ID Prefix F0328 Reg. # 483.25(k) LSC	Correction Completed 06/01/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/01/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TB 9/22/14	Date:	Signature of Surveyor: Linda Brown	Date: 9/18/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/17/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Reviewed and approved 8/18/14 Linda Brown RN

Notified DON at 9:45 AM 8/18 alt NHA OOB. Let her know about DOC chk for result to day it was done.

RECEIVED
WY Dept of Health
JUL 27 2014
Healthcare Licensing and Surveys

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

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 ___	R 07/01/2014

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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 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, 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	{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 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	7/16/14

8/18/14 DSO LB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE
(X6) DATE: 7/29/14

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 225}	Continued From page 1 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. 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	{F 225}	requirements on 7/8/14. The facility will perform reference checks in accordance with corporate policy. 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. 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.	

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{F 225}	Continued From page 2 made no attempt to attain additional factual information regarding the misdemeanor charges. b. Interview with the administrator on 7/1/14 at 4:05 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 also 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 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	{F 225}	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 3 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 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.	{F 225}		

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{F 225}	Continued From page 4 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}		