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

PRINTED: 06/21/2016
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
	535031	A. BUILDING _____ B. WING _____	C 06/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(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 Surveys on 6/6/16 through 6/7/16. Complaint reviewed in the course of this survey was complaint intake WY000002243. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	
F 225 SS=D	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	F 225	F225 Resident #37 had an event investigation completed and reported to the appropriate agencies on 6.13.16. ~~Abuse could not be substantiated.~~ Customer service education will be ~~has been~~ completed with the ~~LPN~~ Alleged Perpetrator involved in the allegation. Staff member will be Skin assessments completed for current residents in house. ~~or~~ Investigations ~~were~~ will be completed on any abnormal findings ~~including skin tears~~ and bruising.	6-30-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 6-30-16

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.

RECEIVED
WY Dept of Health
JUN 30 2016
Healthcare Licensing and Surveys

Spoke to JoAnn Aldrich Administrator on 7/14/16. Plan of Correction accepted & agreed upon changes. Tim

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F 225	Continued From page 1 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 observation, medical record review, staff interview, review of written staff statements, review of facility incident logs, review of State agency logs, and review of facility policy and procedure, the facility failed to thoroughly investigate 1 of 1 allegations of abuse (involving resident #37). Further, the facility failed to report the allegation of abuse to the State survey and certification agency and other officials in accordance with State law. The findings were: 1. Interview with CNA #2 on 6/6/16 at 3 PM revealed "about 3 weeks" prior a nurse was "dragging" resident #37 by the hands and the resident stated, "you are hurting me." Further, CNA #2 revealed 2 staff members observed the incident and reported it to the DON. The following concerns were identified:	F 225	F225 cont'd: Residents have been interviewed to validate that they feel safe, treated with dignity and any concerns or problems they may have. Incident reports completed and appropriate agencies notified of any allegations. Staff ~~have been~~ will be re-educated on ensuring 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 regulation. ~~on~~ Director of Nursing Services (DNS) and Executive Director (ED) ~~have been~~ will be re-educated on state and company regarding abuse and neglect by the Regional Vice President (RVP). ~~on~~	

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F 225	Continued From page 2 a. Interview with the DON on 6/6/16 at 5 PM revealed she was notified via text message on either 5/14/16 or 5/15/16 that a staff member was concerned about a care issue; however, she was unsure which day it was reported and she did not talk to the reporting staff member until the day after it was reported. She stated the incident was not investigated because she did not feel it was an allegation of abuse; however, she did request written statements from 2 staff members that witnessed the incident and interviewed the nurse that was named in the allegation. b. Review of the facility incident log on 6/6/16 showed no evidence an abuse allegation was reported to any agency or thoroughly investigated. c. Review of a written staff statement from CNA #5 dated 5/16/16 showed the nurse was "dragging" resident #37 to the dining area and the resident stated, "Let go of me. You're hurting me." Further, the statement showed the incident occurred on 5/14/16. d. Review of a written staff statement from CNA #2 dated 5/14/16 showed at approximately 10:30 AM, a staff member was "dragging" resident #37 as the resident stated "your [sic] hurting me, let go." Further, at approximately 3:30 PM the resident stated his/her hands hurt. Interview with the CNA on 6/7/16 at 9:06 AM revealed at the time of the incident, the resident was being assisted to ambulate by the nurse. The nurse was facing the resident and walking backward while holding the resident's hands. The resident attempted multiple times to pull his/her hands away and the nurse would grasp the resident's hands again. Further, it was revealed that the nurse changed his grip on the resident's hands each time the resident pulled his/her hands away.	F 225	F225 cont'd: All Allegations of alleged violations will be reviewed by ED and DNS with guidance from RVP and Regional Director of Clinical Operations (RDCO) for timely report according to state regulations. Weekly audits of skin for any unknown source of injury will be conducted for four weeks. Findings of audits to be brought to QAPI for evaluation and further educational opportunities by the DNS.	

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F 225	Continued From page 3 e. Review of the weekly skin evaluations dated 4/17/16, 5/1/16, and 5/8/16 showed the resident's skin was clean, dry, and intact with no noted skin issues. f. Review of the weekly skin evaluation dated 5/15/16 (the day after the alleged incident) for resident #37 showed the resident had "bruising on top of both hands." g. Review of a nurse's note dated 5/16/16 and timed 12:25 AM showed the resident had "bruising to the top of both hands." h. Review of a nurse's note dated 5/16/16 and timed 11:50 AM showed the facility contacted the resident's family related to the hand bruises. Further, the note showed the resident hit his/her hands on the wall to get people's attention; however, there was no documentation in the nurse's notes between 3/21/16 and 5/15/16 that showed the resident was hitting the wall. i. Interview with the DON and administrator on 6/6/16 at 7:13 PM revealed the facility did not consider the bruised hands as part of the incident because the resident's hands were "always bruised." j. Interview with CNA #2 on 6/7/16 at 9:06 AM revealed resident #37 did hit the wall with his/her hands; however, she had only observed the resident hit the wall with an open palm. k. Interview with CNA #3 on 6/7/16 at 9:32 AM revealed the CNA had never seen the resident hit the wall with his/her hands or display any behaviors. l. Interview with CNA #4 on 6/7/16 at 9:40 AM revealed resident #37 had verbal behaviors; however, she had never seen the resident hit the wall with his/her hands. Further, she stated the resident was always friendly and his/her behaviors may be related to staff approach. m. Observation on 6/7/16 at 9 AM showed	F 225		

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F 225	Continued From page 4 resident #37 had discoloration on his/her left hand near the thumb; however, there was no evidence of bruising or trauma noted to the top of the hands. I. Review of the State survey agency logs showed the incident was not reported to that agency until 6/13/16. 2. Interview with the DON and administrator on 6/7/16 at 9:58 AM revealed the incident was not investigated because the facility did not recognize it as an allegation of abuse. Further, it was confirmed that the facility should have reported the allegation to the State survey agency immediately. 3. Review of the facility policy titled "Event Reporting and Investigation" updated 07/14 showed "Policy Statement: The Center documents and investigates events involving allegations of mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property in accordance with state and federal regulatory requirements...Substantial Event: a. any event reportable to state and federal agencies as defined by those agencies (i.e. abuse, injury of unknown source, etc.)....Event Investigation...1. When an event is discovered, the employee making the discovery should immediately notify their immediate supervisor. The nurse evaluates the resident and provides first aid as appropriate prior to beginning report form. As applicable, follow state regulations related to mandatory reporter...3. The Center should use the Event Investigation Report for reporting and documenting events for the Center and to the VSO [Vancouver Service Office]. (If State agency requires a specific form, then the center uses that specific form for	F 225		

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F 225	Continued From page 5 reporting to the state agency only.) 4. If the event is substantial or involves allegations of mistreatment, neglect, abuse, including injuries of unknown origin or misappropriation of resident property is suspected, the Executive Director (ED) or designee is notified immediately...9. The DNS [Director of Nursing Services] verifies documentation and follow-through of the investigation are entered in the resident's medical record at the end of the investigation. 10. The ED or DNS notifies the state survey and certification agency and appropriate state agency per state regulation within the required timeframe established by state regulation...12. The Interdisciplinary Team completes the Event Investigation Final Summary. Additionally, the IDT summarizes the event in the IDT section of the medical record...14. The ED or DNS maintains the Monthly Event Investigation Log with entries recorded at Center Clinical Meeting...Event Reporting...2. Regulatory Reporting...b. Events involving allegations of abuse, neglect, mistreatment, misappropriation of resident property, or injuries of unknown source are reported immediately to the state survey and certification agency. Additional reporting may be required to the Center ombudsman, adult protective services, and the police per state requirements. Reporting is also made to the resident's physician and the resident's authorized representative...d. Results of investigations of events involving allegations of abuse, neglect, mistreatment, or misappropriation of resident property or injuries of unknown source are reported to the state survey and certification agency within 5 working days of the event. If the allegation is substantiated, the results should include a description of corrective action taken..."	F 225		