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 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 A complaint survey was conducted by Healthcare Licensing and Surveys from 8/21/23 to 8/22/23. The survey was prompted by complaint intake WY000003655.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, review of facility incident reports and investigations, and facility policy review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 5 residents (#1) reviewed for abuse. This failure resulted in harm to resident #1, who sustained facial bruising after being struck by another resident. The findings were: Review of the 7/10/23 annual MDS assessment for resident #1 showed the resident was rarely/never understood, wandered daily during	F 600	1. Resident #2 started on new medications resulting in no further outburst of anger or aggression towards staff or other residents. Resident #1 bruise is healed, has no memory of incident described in the 2567 and behavior remains at baseline. 2. Social Services Director or designee will complete an audit of residents to assess for other residents who may have experienced or are fearful of an abuse situation. Increased evening shift staffing in the Special Care Unit to assist with	9/13/23

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

Electronically Signed | 09/11/2023

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F 600	Continued From page 1 the lookback period, and walked with a walker with staff supervision. The resident had diagnoses of arthritis, and Alzheimer's disease. The resident did not take anticoagulants but did take antipsychotic medication during the last 7 days of the MDS look back period. The resident was not coded as having behaviors directed towards others. Review of the 8/1/23 quarterly MDS assessment for resident #2 showed diagnoses which included non-Alzheimer's dementia and diabetes mellitus. The resident had severely impaired cognitive skills, had physical and verbal behaviors towards others, and wandered 1 to 3 days during the lookback period. The resident walked using a walker with staff supervision. The following concerns were identified: 1. Review of the facility's 8/4/23 incident report showed on 8/4/23 at approximately 8:15 PM, CNA #1 was walking resident #1 to his/her room from the unit dining room. As they came to the split in the hall, resident #2 was walking on the other side of the hallway. Unprovoked, resident #2 reached out and hit resident #1 in the face with a semi-closed right hand. CNA #1 immediately intervened and redirected resident #2 to his/her room, then called for a nurse over the walkie-talkie system. LPN #3 came to assess resident #1, and found a bruise forming under his/her left eye where s/he had been struck by resident #2. Local law enforcement, physicians for both residents, and families for both residents were notified. Review of the facility's investigation of the incident showed staff were unable to determine what provoked the incident. a. Interview on 8/21/23 at 7 PM with CNA #1 revealed on 8/4/23 while walking with resident #1,	F 600	positive resident interactions. 3. RVP reeducated Executive Director on the Abuse Prevention Policy. Executive Director reeducated staff on Abuse Prevention Policy to validate Abuse prevention procedures are followed. Executive Director or designee will randomly interview five (5) staff members regarding abuse prevention measures a week for 4 weeks, then monthly x2 months to validate abuse prevention procedures are followed. Social Services Director or designee will randomly audit three (3) residents a week to assess for residents who may have experienced or are fearful of an abuse situation. Care plan for Resident #2 updated to reflect medication change and increased supervision during medication change monitoring period. Facility assessment updated to reflect staffing changes in the memory care unit based on Resident needs. 4. Executive Director or designee will bring audit results to QAPI, for 90 days or until substantial compliance. 5. Date of compliance will be 9/13/23.	

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F 600	Continued From page 2 resident #2 walked beside resident #1 and used the back of his/her hand with a semi-closed fist and hit resident #1 in the left side facial area, leaving a mark. Furthermore, the staff member stated resident #2 made a statement that resident #1 took her blanket. The staff member also stated the action was intentional by resident #1. b. Interview on 8/22/23 at 2 PM with the executive director and regional nurse consultant confirmed resident #1 was hit in the face by resident #2. c. Observation on 8/21/23 at 4:30 PM showed resident #1 walking in the hall with a green bruise covering an area from the left eyelid to the left cheekbone. d. Review of the policy titled "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation" updated October 2022 showed: That each resident had the right to be from physical abuse; defined "Willful" as when the individual acted deliberately, not that the individual must have intended to inflict injury or harm, physical abuse included hitting and slapping, and further review showed resident to resident abuse altercations are reviewed as potential abuse.	F 600		