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 03/06/2024

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 3/5/24 to 3/6/24. The survey was prompted by complaint intake WY00003816. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant ED: Executive Director LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	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 medical record review, staff interview, facility grievance log review, policy and procedure	F 600	Corrective Action: CNA #2 was suspended 3/5/2024 pending	4/1/24

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

Electronically Signed | 03/29/2024

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F 600	Continued From page 1 review, and State Survey Agency incident database review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 of 3 sample residents (#1) reviewed for abuse. This failure resulted in actual harm to resident #1 who experienced verbal abuse a reasonable person would have found humiliating, intimidating, demeaning, and degrading. The findings were: 1. Review of the 12/13/23 quarterly MDS assessment showed resident #1 had a mood score of 00 and did not exhibit any behaviors, wandering, or rejection of care during the 7-day look-back period. Further review showed the resident was frequently incontinent of urine and occasionally incontinent of bowel. Review of the resident's care plan showed special instructions to document every shift if the resident had an increase in confusion episodes, escalations in voice, "perseverations", or changes in mood or behavior. The following concerns were identified: a. Review of a grievance form, provided by staff #1 and written by CNA #1, showed "I witnessed [CNA #2] tell [the resident] [s/he] smelled wrong and [s/he] needed to come with him. [The resident] told him [his/her] pants were dry and was refusing. He leaned toward (sic) and yelled loudly at [the resident] to 'Stop I don't have to listen to this Get up!' [The resident] said no and he grabbed [the resident's] left hand and tried to pull [the resident] out of the chair." At that time, CNA #1 stepped in and told CNA #2 he would take over the situation. The grievance form showed the incident occurred on 2/24/24 at 3 PM and was submitted to the business office manager (BOM) on 2/25/24. b. Review of a witness statement, provided by staff #1 and written by LPN #1, dated 2/24/24	F 600	an investigation. Resident #1 was interviewed by nursing/designee. Care Plan of Resident #1 reviewed and updated as deemed necessary. Identification: Residents who currently reside in the facility are at potential risk. No similar findings and/or have been identified by this alleged deficient practice. Systemic Changes: ED and DNS were educated by Regional Nurse Consultant on investigating/Prevent/Correct Alleged Violations. All will be re-educated on abuse reporting notification and investigation by ED/DNS/Designee on or before the allegation of compliance. All staff on leave will be trained before the start of the shift. All staff will receive continued education during orientation and annually by DNS/Designee. Monitoring: IDT will review grievances during morning stand-up to ensure the facility appropriately responds and investigates allegations of potential abuse. The ED/Designee will interview five (5) staff members and (5) residents a week to ensure potential abuse has been reported and investigated for three months then two (2) times monthly thereafter to ensure ongoing and sustained compliance. Any adverse findings will be immediately addressed and reported to the ED/Designee as deemed necessary. Findings and trends will be reported to QAPI Committee for further review and consideration.	

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F 600	Continued From page 2	F 600		

and timed 3 PM, showed "I heard a man yelling at the end of the hall, down from nurse's station. The man was heard yelling and so was patient [the resident]. I realized it was [CNA #2] yelling and immediately started down the hall. By the time I arrived where [CNA #2] and patient were, the other [CNA #1] stepped in and was assisting patient with [his/her] care. [CNA #2] was yelling directly in the patient's face while [CNA #1] was positioning himself between patient and [CNA #2]. Upon my arrival I quickly went to assist [CNA #1] with patient. Patient was noticeably upset, so [CNA #1] and myself assisted patient to [his/her] room.

c. Review of the February 2024 grievance log showed no evidence of the grievance filed by CNA #1.

d. Telephone interview with LPN #1 on 3/5/24 at 5:16 PM revealed she was at the nurse's station when she heard a man "yelling" and a resident yelling back. The LPN described the yelling to be a "different sound" than what was normally heard. When she got to the dayroom, she witnessed CNA #2 directly in front of the resident and CNA #1 placing himself between CNA #2 and the resident. Further the LPN stated the resident "upsets easily" and she observed the resident to have a "frowny face" and was yelling back at CNA #2.

e. Telephone interview with CNA #1 on 3/5/24 at 5:29 PM revealed he was in the dayroom on 2/24/24 when CNA #2 walked in front of resident #1 and told the resident "You don't smell right" and grabbed the resident's hand and tried to pull him/her out of the chair. The resident protested and said "no" stating his/her pants were dry. At this time CNA #2 got in the resident's face and started yelling "Stop I don't have to listen to this you are coming with me". CNA #1 stated he

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reported the incident to the BOM who then asked him to fill out a grievance form which he gave to her on 2/25/24. Further the CNA stated the resident's "tone of voice was elevated and the pitch was really high." Further interview revealed the resident exhibited a high pitched voice when s/he was upset.

f. Interview with CNA #2 on 3/5/24 at 5:58 PM revealed he did not recall having any negative interactions with resident #1. He stated the resident did not want male caregivers so he "respected [his/her] stance."

g. Review of the resident's care plan showed no documentation of a refusal for male caregivers. Interview with the DON on 3/6/24 at 9:48 AM revealed she was unaware of any request by the resident for only female caregivers. In addition, she stated the resident was cared for on a routine basis by male CNAs on the night shift.

h. Review of the State Survey Agency incident database showed an incident was submitted by the facility on 3/5/24 at 8:34 PM. Further review showed "allegation of abuse of yelling at resident and rough with cares. Staff member suspended, residents (sic) does not recall the event. Investigation started."

i. Interview on 3/6/24 at 12:09 PM with the regional nurse consultant, ED, and DON revealed the facility was not aware of what happened to the grievance form submitted by the BOM. Further interview revealed the DON would feel frustrated if she was in the resident's position, the incident was not "okay," and she would be upset.

2. Review of the policy titled "Prevention of Abuse, Neglect, Involuntary Seclusion, Exploitation, and Misappropriation of Resident Property", last updated September 2017, showed

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F 600	Continued From page 4 "1. The Center utilizes the grievance process for concerns expressed by residents, family members, visitors, or others within the Center...4. The Center utilizes a separate Grievances Process for concerns expressed by staff members...7. Center supervisors and staff (as appropriate) correct and intervene in reported or identified situations in which abuse, neglect, exploitation, or misappropriation of property is more likely to occur by analyzing the following...d. The supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, etc...11. Retaliation against staff or others for reporting concerns is strictly prohibited and will lead to disciplinary action."	F 600		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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	F 610		4/1/24

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F 610	Continued From page 5 by: Based on observation, staff interview, and review of staffing schedules, review of the facility grievance log, and review of policy and procedure, the facility failed to respond to an allegation of abuse and protect the resident's right to be free from verbal abuse by a staff member for 1 of 1 sample resident (#1) reviewed. This failure resulted in a delay in an investigation which left the residents unprotected, and a determination of immediate jeopardy. The census was 28. The findings were: 1. Review of a grievance form, provided by staff #1 and written by CNA #1, showed "I witnessed [CNA #2] tell [the resident] [s/he] smelled wrong and [s/he] needed to come with him. [The resident] told him [his/her] pants were dry and was refusing. He leaned toward (sic) and yelled loudly at [the resident] to 'Stop I don't have to listen to this Get up!' [The resident] said no and he grabbed [the resident's] left hand and tried to pull [the resident] out of the chair." At that time, CNA #1 stepped in and told CNA #2 he would take over the situation. The grievance form showed the incident occurred on 2/24/24 at 3 PM and was submitted to the business office manager (BOM) on 2/25/24. 2. Review of a witness statement, provided by staff #1 which was written by LPN #1, dated 2/24/24 and timed 3 PM, showed "I heard a man yelling at the end of the hall, down from nurse's station. The man was heard yelling and so was patient [the resident]. I realized it was [CNA #2] yelling and immediately started down the hall. By the time I arrived where [CNA #2] and patient were, the other [CNA #1] stepped in and was assisting patient with [his/her] care. [CNA #2] was	F 610	Corrective Action: CNA #2 was suspended 3/5/2024 pending an investigation. Resident #1 was interviewed by nursing/designee. Care Plan of Resident #1 reviewed and updated as deemed necessary. Identification: Residents who currently reside in the facility are at potential risk. No similar findings and/or have been identified by this alleged deficient practice. Systemic Changes: ED and DNS were educated by Regional Nurse Consultant on investigating/Prevent/Correct Alleged Violations. All will be re-educated on abuse reporting notification and investigation by ED/DNS/Designee on or before the allegation of compliance. All staff on leave will be trained before the start of the shift. All staff will receive continued education during orientation and annually by DNS/Designee. Monitoring: IDT will review grievances during morning stand-up to ensure the facility appropriately responds and investigates allegations of potential abuse. The ED/Designee will interview five (5) staff members and (5) residents a week to ensure potential abuse has been reported and investigated for three months then two (2) times monthly thereafter to ensure ongoing and sustained compliance. Any adverse findings will be immediately addressed and reported to the ED/Designee as deemed necessary. Findings and trends will be reported to	

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F 610	Continued From page 6 yelling directly in the patient's face while [CNA #1] was positioning himself between patient and [CNA #2]. Upon my arrival I quickly went to assist [CNA #1] with patient. Patient was noticeably upset, so [CNA #1] and myself assisted patient to [his/her] room. The following concerns were identified: 1. Observation on 3/5/24 from 2:15 PM until 6 PM showed CNA #2 was in the facility and providing care to the residents. 2. Review of the 2024 February and March nursing schedule showed CNA #2 worked a 12-hour shift on 2/25, 3/1, 3/2, 3/3, 3/4, and 3/5. 3. Review of the February 2024 grievance log showed no evidence of the grievance filed by CNA #1. 4. Staff interviews were conducted on 3/5/24 from 3:45 PM through 6:08 PM. a. Interview with the BOM at 4:44 PM revealed CNA #1 had verbally informed her of an incident involving CNA #2 and the resident. The BOM asked CNA #1 to "put it in writing" and after he did so she gave the grievance form to the ED. The BOM was unaware of the outcome of the grievance. b. Telephone interview with LPN #1 at 5:16 PM revealed she was at the nurse's station when she heard a man "yelling" and a resident yelling back. The LPN described the yelling to be a "different sound" than what was normally heard. When she got to the dayroom, she witnessed CNA #2 directly in front of the resident and CNA #1 placing himself between CNA #2 and the resident.	F 610	QAPI Committee for further review and consideration.	

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F 610	Continued From page 7	F 610		

c. Telephone interview with CNA #1 at 5:29 PM revealed he was in the dayroom on 2/24/24 when CNA #2 walked in front of resident #1 and told the resident "You don't smell right" and grabbed the resident's hand and tried to pull him/her out of the chair. The resident protested and said "no" stating his/her pants were dry. At this time CNA #2 got in the resident's face and started yelling "Stop I don't have to listen to this you are coming with me". CNA #1 stated he reported the incident to the BOM who then asked him to fill out a grievance form which he gave to her on 2/25/24.

d. Interview with CNA #2 at 5:58 PM revealed he did not recall having any negative interactions with resident #1. He stated the resident did not want male caregivers so he "respected [his/her] stance."

5. On 3/5/24 at 7:20 PM the ED was informed of an immediate jeopardy situation in the area of abuse related to the failure to investigate an allegation of abuse and provide protection to residents.

6. The facility submitted an action plan which included the following immediate changes:

a. CNA #2 was suspended on 3/5/24 pending an investigation.

b. An abuse allegation investigation was started which included resident interviews and reporting of the allegation to the appropriate entities.

c. Education was provided to all staff on abuse reporting notification and investigation which included education of oncoming staff before contact with residents.

6. The action plan was accepted on 3/6/24 at

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F 610	Continued From page 8 11:36 AM. 7. The implementation of the action plan was verified and immediacy was removed on 3/6/24 at 12:08 PM; however, deficient practice remained at a scope and severity of "E." 8. Review of the 2017 "Abuse Reporting and Response" policy and procedure showed "1. Staff immediately reports all alleged or suspected violations immediately to the supervisor and Executive Director."	F 610		