

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Thermopolis Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1210 Canyon Hills Rd Thermopolis, WY 82443	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37220</p> <p>Based on medical record review, staff interview, facility grievance log review, policy and procedure 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:</p> <p>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:</p> <p>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.</p> <p>b. Review of a witness statement, provided by staff #1 and 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 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.</p> <p>c. Review of the February 2024 grievance log showed no evidence of the grievance filed by CNA #1.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 535051	Facility ID: 535051 If continuation sheet Page 1 of 4

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>2. Review of the policy titled Prevention of Abuse, Neglect, Involuntary Seclusion, Exploitation, and Misappropriation of Resident Property, last updated September 2017, showed 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.</p>		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<p>Respond appropriately to all alleged violations.</p> <p>37220</p> <p>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:</p> <p>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.</p> <p>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 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.</p> <p>The following concerns were identified:</p> <p>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.</p> <p>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.</p> <p>3. Review of the February 2024 grievance log showed no evidence of the grievance filed by CNA #1.</p> <p>4. Staff interviews were conducted on 3/5/24 from 3:45 PM through 6:08 PM.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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