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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thermopolis Rehabilitation and Wellness	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, staff interview, state survey agency incident database review, and policy and procedure review, the facility failed to accurately and timely report allegations of abuse for 1 of 13 sample residents (#1) reviewed for reportable allegations. The findings were:1. Review of a progress note for resident #1 dated 1/3/26 and timed 3:26 PM showed This nurse was sitting in the dining room with residents. [resident #1] was walking around calmly as normal. [S/He] got close to another resident, and without any queue, wound back with a clenched fist and punched a sitting resident in the face. Resident was immediately redirected and didn't seem to recall any of the situation seconds prior. Resident was immediately removed from situation, and placed on one on one. Resident has no recollection of event so only intervention is one on one at this time . 2. Review of an Allegation of Resident to Resident Abuse for resident #2 dated 1/3/26 and timed 3 PM showed Resident was sitting in dining room when another resident punched [him/her] in the face. Resident did nothing to incur the event and does not recall the situation moments later. Further review showed Resident that caused the incident was removed and put on one to one. This resident was assessed for injury. There is a red mark on [his/her] cheek, but appears to have already been there. No swelling or pain noted. 3. Review of a facility reported incident dated 1/3/26 and timed 5 PM showed Resident [#1] walked near resident [#2] and pushed [his/her] face. Resident [sic] separated and redirected. No injury or distress noted for both residents. Further review showed the allegation was reported on 1/4/26 at 5:45 PM, 24 hours and 45 minutes after the alleged incident. 4. Interview with RN #1 on 2/26/26 at 1:59 PM revealed he did not recall the incident; however, whatever he had documented is what he would have reported to the facility administration. 5. Interview with the administrator on 2/26/26 at 1:09 PM confirmed the allegation resident #1 punched resident #2 was not accurately reported by the facility. The administrator revealed the investigation, which was initiated following the allegation resident #1 punched resident #2, determined resident #1 pushed resident #2. The administrator confirmed the facility reported the results of the investigation as the allegation and not the actual allegation. 6. Review of the policy titled Abuse Reporting and Response published September 2017 showed .4. The Executive Director of designee reports alleged violations to the state survey agency and others officials in accordance with state law (such as Adult Protective Services and local law enforcement as follows: a. Immediately but not later than 2 hours-All allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that cause the allegation involve abuse or result in serious bodily injury .

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