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

PRINTED: 02/25/2011
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
	535051	A. BUILDING _____ B. WING _____	C 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD 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 The following common abbreviations are used throughout this document: CNA-Certified Nurse Aide LPN-Licensed Practical Nurse MDS-Minimum Data Set ROM-Range of Motion DON-Director of Nursing MAR-Medication Administration Record mg-milligrams COTA-Certified Occupational Therapy Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000	Initial comments Preparation and execution of this Response and plan of correction does not constitute an 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 law. For the purposes of any allegation that the facility is not in substantial compliance with Federal Requirements of participation this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 7317A of the State Operations Manual.	
F 157 S=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	F157 483.10 (b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.) The facility will ensure that notification of changes to the resident, the physician, and the family and/or representative of the resident. This will be accomplished by: A) All nurses will receive another In-service related to the timely consultation with the resident, physician, and family of any significant change in the holistic status of residents. In-services on documentation of all physician, family and resident contacts have been, and will continue to be, accomplished. An in-service was conducted on March 4, 2011, to assure facility compliance with the noted insufficiency in the State Survey. The noted insufficiency in documentation related to Resident #39 was addressed with the Nursing Staff at that time, (March 2010). Documentation continues to be a routinely emphasized subject at regular monthly Nursing Department meetings. B) DON or designee will receive report from charge nurses, reviewing potential status changes and the DON or designee will instruct Charge Nurse to consult with the resident's physician and discuss the concerns	3/27/11

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

Revised Plan of Correction — Administrator — 3/23/11

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.

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Wyoming Dept of Health
MAR 23 2011
Office of Healthcare Licensing and Surveys

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GCQ011 Facility ID: WY0003 If continuation sheet Page 1 of 19

THIS POC approved with agreed to change between the Social Services Director (DAVIS) and Tony Madden on 3/24/11. 3/24/11

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately inform the resident's physician and family of a significant change for 1 of 3 sample residents (#39) who had a significant physical decline. The findings were: Review of the nurse's notes from 3/20/10 showed the resident had become "very lethargic" and had poor meal intake. During a seven day period, the resident was noted to have slept for long periods during the day and was found slumped over, and refused to hold his/her head up on several occasions. During meals the resident would hold food in his/her mouth and then spit it out or would not eat at all. Review of the physician's orders showed staff did not contact the resident's doctor until 3/28/10, at which time the physician ordered a urinalysis and antibiotics. A family member was also contacted at that time. On 3/30/10 the nurse's notes showed the resident was responsive to painful stimuli only. A family member was contacted and s/he requested an ambulance to take the resident to the local emergency room (ER). The physician was also notified, and the resident was transported to the ER. Review of the weekly weight record showed	F 157	with the resident and his/her family/rep. if applicable. C) In an effort to improve communication between staff, residents and family members, a resident communication form was developed and implemented in October of 2010. This form continues to be utilized and has been successful in improving the communication and follow-up of noted resident status concerns. D) Policy was reviewed for the facility's Weight Committee and determined to need updating. This updated facility policy for Weight Management was developed January 2011 addressing weight changes and actions to be taken within the parameters given. E) Weekly meetings involving DON, Dietary Manager, MDS Coordinator, Wound Care Nurse, and the Administrator are being conducted to review weights, skin issues, and nutritional status. Information regarding resident concerns identified at this meeting is reported to the physician, the resident and the resident representative as appropriate. Weight, skin, and nutritional issues were being monitored by the Registered Dietician, the Wound Care Nurse and the IDT team on an as needed basis, prior to the institution of the re-written policy. The Weekly Weight meetings were implemented in January 2011. F) Weight Meeting minutes will be reviewed, as is protocol, at each monthly QA/QCI committee meeting. This review will remain on-going.	

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F 157	Continued From page 2 the resident's weight on 3/23/10 was 175.8 pounds, and on 3/30/10 was 165.4 pounds, a 10.4 pound weight loss. Interview with the DON on 2/17/11 at 2 PM revealed there was no further documentation showing the nursing staff had contacted the physician and/or family member of the resident's significant change during the seven day period.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to promote dignity for 3 of 12 sample residents (#11, #32, #42) and 3 non-sample residents (#4, #5, #20) who required assistance with dining. In addition, the facility failed to promote dignity for 1 of 10 sample residents (#11) who required assistance with toileting, and 1 of 12 sample residents (#42) who required assistance with dressing. The facility also failed to answer a call light in a timely manner for one non-sample resident (#40). The findings were: 1. Review of the 11/8/10 quarterly MDS assessment for resident #42 revealed the resident had cognitive impairment and required assistance with dining. Observation in the main dining room on 2/8/11 at 7 AM revealed staff helped the resident with coffee, juice, and water prior to serving the breakfast trays. Observation	F 241	F241 483.15 (a) DIGNITY AND RESPECT OF INDIVIDUALITY 1. Dignity r/t Dining Experience The facility will ensure that the dining experience will preserve the individual and collective resident's rights to dignity and personal choice. This will be accomplished by: A) All nursing and dietary staff will receive in-service as to the importance of maintaining and enhancing resident dignity. This will be provided on March 4, 9, 10, and 25, 2011. B) Social activities are provided prior to all meals being served. The Dining Room area is considered a social environment. Activities will be implemented during the dining experience. C) Residents requiring assistance with nutritional intake will not be seated at a dining table without staff assistance. Resident numbers 11, 32, 42, 4, 5 and 10, and all residents with assisted dining needs, are now seated in the dining room no earlier than 15 minutes prior to dining time. This will assure that the right to a dignified and pleasant dining experience will be observed for individuals who require assistance. D) Weekly monitoring of the dining room protocol will be conducted by DON, Dietary Manager or their designee. The weekly monitoring will be reported to the QA/QCI committee on a monthly basis. E) If there are no identified issues this will be considered resolved by QA/QCI at July QA/QCI meeting. 2. Dignity r/t toileting assistance The facility will ensure that the residents will receive timely assistance with personal needs while preserving the individual and collective resident's rights to dignity	3/27/11

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F 241	Continued From page 3 at 7:15 AM revealed the resident was directed to sit at the assisted dining table. Within half an hour, five additional residents (#4, #5, #11, #20, #32) were positioned at the same table with resident #42. The six residents did not receive food or fluids. They stared at the table and periodically dozed while staff served and assisted other residents. At 8:10 AM, the six residents were served breakfast and received assistance (fifty-five minutes had elapsed since resident #42 was brought to the table). Interview with the DON on 2/10/11 at 2:15 PM revealed the residents who required dining assistance should not have to wait fifty-five minutes for staff to assist them. 2. During an observation on 2/8/11 at 7:30 AM, CNA #1 assisted resident #27 to the toilet in his/her bathroom. At that time, resident #11 asked the aide for help to go to the bathroom. When the aide stated that resident #27 was in the bathroom, resident #11 stated, "I'm going to pee on myself." The aide then stated, "I don't know what to do," and left the room. During the following 30 minutes, the aide came in and checked resident #27 twice and left. Each time the aide entered the room, resident #11 shouted, "I'm going to pee on myself." The aide gave no response either time and left the room. Several times over the next 30 minutes, resident #11 shouted at resident #27 to get out of the bathroom. At 8:05 AM, the aide came back to the room and the surveyor asked if there was an alternative way to toilet resident #11. The aide left the room and momentarily came back with the DON. The DON stated that resident #11 would be toileted in the hallway restroom, and the aide took resident #11 to the hallway toilet at that time (35 minutes after the resident's initial request for toileting assistance).	F 241	and personal choice. This will be accomplished by: A) All nursing staff will receive in-service related to alternate areas in the facility where residents may be assisted with toileting needs. This will be provided on March 4, 9, 10 and 25, 2011. B) The first bathroom located on the right hand side of Hall D has been designated for use as alternative restroom for residents. C) At the time of the noted insufficiency, Resident #10 was accompanied to another restroom in the facility, and assisted. 3. Dignity r/t clothing The facility will ensure individual and collective resident's rights to dignity and personal choice. This will be accomplished by: A) Staff will be educated regarding appropriate clothing choices for residents. This will be provided on March 4, 9, 10, and 25, 2011. B) Resident's family members are notified upon admission of recommended clothing choices for comfort, ease of use, etc. The resident and their representatives are allowed the latitude of personal choice for their preferred mode of dress. C) This facility will recommend appropriate clothing for residents, and will utilize those clothing items provided by the resident and their families/representatives. D) Resident #42's responsible family member has been contacted and asked to remove the article of clothing, to assure that the Resident #42 does not have access to that particular clothing item. 4. Dignity r/t call light time frame Per insufficiency identified with Resident #40, the facility will ensure that Resident #40 and all residents will receive timely assistance with personal needs while preserving the individual and collective resident's rights to dignity and personal choice. This will be accomplished by: A) Staff will be in-serviced on answering call lights in a timely manner. Timely manner is defined as no longer than 3 minutes from on-set, per notation by survey team. This will be provided on March 4, 9, 10, and 25, 2011.	

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F 241	Continued From page 4 During an interview with the aide immediately after the observation, she stated that resident #27 usually did not take that long to use the bathroom, so she just waited. During an interview with the DON on 2/10/11 at 2 PM, she stated that staff had been educated to utilize the hallway bathroom for a resident if his/her bathroom was unavailable. 3. Review of the 11/8/10 quarterly MDS assessment for resident #42 revealed the resident was cognitively impaired and required extensive assistance with dressing. Observation on 2/6/11 from 7:15 AM until 1:20 PM revealed the resident's disposable brief was visible through the thin fabric of the resident's slacks. The brief was clearly visible when the resident walked in the halls or went to activities and meals. 4. Observation on 2/8/11 at 11 AM revealed resident #40 turned his/her call light on and staff did not respond until 11:15 AM (fifteen minutes). Interview with NA #2 on 2/9/11 at 1:50 PM revealed she was unable to respond to the call light in a timely manner because she was performing other duties. During an interview with the resident on 2/10/11 at 1:15 PM, s/he stated that waiting for staff to respond to his/her call light while in the bathroom is "very frustrating." Interview with the DON on 2/10/11 at 2:15 PM revealed the expectation was that call lights would be answered within three minutes.	F 241	B) Call light timing will be monitored by DON or designee 3 times per week for a 90 day time frame. Those individual staff members not responding timely will be immediately in-serviced at the time of incident. C) Results of those audits will be reviewed at the monthly QA/QCI meeting. If there are no trends or issues, the QA/QCI team will terminate the review requirement at the July quarterly meeting.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide maintenance to ensure the doors and walls in 16 of 36 resident rooms and one hallway were in good repair. The findings were: 1. Observation during a tour of the facility from 9:30 AM through 10:15 AM showed the following doors and door frames had noticeable damage: a. In room #1 the bathroom door frame had paint scraped off from the floor to a height of 22 inches on one side and 18 inches on the other. b. In room #3, the inside bathroom door had a gash 3 inches up from the floor that was 23 inches across. c. In room #6, the inside bathroom door kick plate was loose from the door on the inner side from the bottom to 11 inches high. d. In room #7, the inside bathroom door had a gash that was 3 inches above the floor and 35 inches in length. e. In room #8, the inside bathroom door had a 23-inch gash located 3 inches above the floor. f. In room #9, the inside bathroom door had three gashes that were 23 inches in length. g. In room #11, the inner side front door kick plate had a 19 inch by 1 inch chip. h. In room #17, the inner bathroom door kick plate had a 3 inch by 2 inch chip. i. In room # 20, the inner front door kick plate had a scraped area from the floor to 2 feet up. j. In room #26, the inner front door had a floor to 22 inch area that had a "chewed" appearance.	F 253	F253 483.15 (h)(2) HOUSEKEEPING AND MAINTENANCE SERVICES 1. Door frames and doors The facility will ensure that cosmetic repairs are conducted and maintained throughout the facility. This will be accomplished by: A) Items a. through n. will be repaired, painted, or replaced by March 27, 2011, by the Maintenance Manager. All doors have been cleaned thoroughly and those that required repair have been/will be attended to. Specifically, the following actions have been/will be taken for: 1.a.) Room #1 – scratches in the paint on the bathroom doors have been repainted with the same paint color as the current paint. 1.b.) Room #3 – a wooden kick plate has been installed on that door and stained with walnut wood stain, and sealed. 1.c.) Room #6 – the kick plate will be or has been glued and tacked into place with approved products. 1.d.) Room #7 – a wooden kick plate has been installed on that door and stained with walnut wood stain, and sealed. 1.e.) Room #8 - a wooden kick plate has been installed on that door and stained with walnut wood stain, and sealed. 1.f.) Room #9 - a wooden kick plate has been installed on that door and stained with walnut wood stain, and sealed. 1.g.) Room #11 - a wooden kick plate has been installed on that door and stained with walnut wood stain, and sealed. 1.h.) Room #17 - a wooden kick plate has been installed on that door and stained with natural wood stain, and sealed. 1.i.) Room #20 – a new door has been installed. 1.j.) Room #26 – inner aspect of the door into the room has been sanded and stained to match. This is the only area that was identified on that door that	3/27/11

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F 253	Continued From page 6 k. In room #33, the inner bathroom door frame had a gash and chipped paint from the floor to 7 inches. l. In room #34, the inner front door kick plate had a 3 inch by 1 inch chip. m. In room #35, the inner bathroom door kick plate was chipped 6 inches by 1 inch. In addition, there was a 2 foot gash on the inside door frame. n. In room #36, the front door kick plate inner side was chipped 2.5 inches by 3 inches. 2. Observation during a tour of the facility from 9:30 AM through 10:15 AM showed the following wall and ceiling damage: a. In room #2, a 5 x 2 inch area of paint was scraped off of the wall at the foot of the first bed. b. In room #3, the distant bathroom wall had a 24 inch scrape where paint was damaged. c. In room #6, the bedroom window had 3 curtain rod holes that had been patched, but not painted. d. In room #7, the bathroom front wall to the back wall had an area where paint was scraped off that was approximately 12 x 18 inches square. e. In room #8, the heat vent attached to the back wall near the floor was detached behind the first bed and was laying on the floor on the right side. f. In room #30, the second bed had a 9 x 4 inch area on the wall at the headboard that had been repaired, but not painted. g. In the hallway outside of room #30, there was a noticeable crack across the entire ceiling that started down both walls. h. In room #35, there was a 9-inch wall repair above the head of the second bed that had	F 263	appeared to be "chewed", thus it is the portion that was repaired. 1.k.) Room #33 – a new door has been installed. 1.l.) Room #34 – a new kick plate has been installed. 1.m.) Room #36 – a new kick plate has been installed. B) A walk through by Administrator or Designee will be conducted after expected completion date to assure compliance has been met. 2. Wall and Ceiling damage A) Items a. through h. will be repaired, painted, or replaced by March 27, 2011 by the Maintenance Manager. 2.a.) Room #2 – repainted 2.b.) Room #3 – repainted 2.c.) Room #6 – painted 2.d.) Room #7 – repainted 2.e.) Room #8 – heater vent cover was re-attached 2.f.) Room #30 – repainted 2.g.) Room #30 hallway – ceiling and wall caulked with paintable caulking, and repainted. 2.h.) Room # 35 – repainted. B) A walk through by Administrator or Designee will be conducted after expected completion date to assure compliance has been met. C) After completion of item #'s 1 & 2 the Administrator or designee will conduct a weekly walk -through identifying needed areas of repair, painting, or replacement. Work orders will be completed and Maintenance Manager will be responsible for completion of necessary repairs and/or replacements. Any newly identified repair issues noted during walk-through will be completed within a one week time frame. D) If the weekly walk-through identifies no areas of required repair, the weekly walk through will be reduced to monthly after 90 days. E) QA/QCI will receive monthly report of accomplished tasks for a 90 day time frame. If tasks are completed on a timely basis the report requirement will be terminated at the July quarterly QA/QCI meeting.	

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F 253	Continued From page 7 not been painted. Interview with the maintenance director on 2/10/11 at 10:30 AM, revealed that he was aware of the issues with doors and missing paint. the issues with doors and missing paint. He further stated that he had not established a schedule or timeframe to repair the identified issues.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to identify a significant change in physical condition for 1 of 2 sample residents (#39) who experienced a significant change in physical status. The findings were: Review of the 3/11/10 admission MDS assessment showed resident #39 weighed 191 pounds, was 66 inches tall, and was not on a planned weight change program. In addition, the	F 274	F274 **483.20(b)(2)(ii) COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE** The facility will ensure that upon notice of significant change in condition in one or more areas of the resident health status, a 14-day comprehensive assessment will be conducted. This will be accomplished by: A) All staff will receive in-service related to reporting significant changes for Resident #39 and all other residents to the interdisciplinary Team. This will be completed on March 4, 9, 10 and 25, 2011. B) DON or designee do/will receive report from charge nurses, reviewing potential status changes and the DON or designee will instruct Charge Nurse to consult with the appropriate Interdisciplinary Team member and discuss the concerns with the resident and his/her family/rep. if applicable. C) In an effort to improve communication between staff, residents and family members, a resident communication form was developed and implemented in October of 2010. This form continues to be utilized and has been successful in improving the communication and follow-up of noted resident status concerns. D) A policy was developed January 2011 addressing weight changes and actions to be taken within the parameters given. E) Weekly meetings involving DON, Dietary Manager, MDS Coordinator, Wound Care Nurse, and the Administrator are being conducted to review weights, skin issues, and nutritional status. Information regarding resident concerns identified at this meeting	3/27/11

3/24/11 AM

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F 274	Continued From page 8 resident was noted to have edema, and no pressure ulcers were present. Review of the nurses' notes revealed the following concerns with the resident's physical status and nutritional intake: a. On 3/20/10 the resident was lethargic and not eating. b. On 3/23/10 the resident continued to be lethargic and refused to hold his/her head up. c. On 3/26/10 the resident was slouching in his/her chair and was very confused. The resident would hold food in his/her mouth and then spit it out when the nursing staff attempted to provide assistance with eating. d. On 3/27/10 the resident continued not to eat. e. On 3/30/10 the resident was responsive only to painful stimuli and was hospitalized. Review of the nurses' notes showed the resident returned to the facility on 4/8/10, following a nine day hospitalization. The following significant changes in the resident's physical condition were noted: a. According to the 4/9/10 nurses' notes and the 4/8/10 "Skin Breakdown Report" the resident had four pressure ulcers: one Stage III pressure ulcer on the coccyx, two Stage II pressure ulcers one on each right and left buttock, and one unstageable ulcer on the left heel. Review of the "Resident Weekly Skin Check Sheet" showed there were no skin issues from 3/8/10-3/29/10 prior to the resident's hospitalization on 3/30/10. b. Review of the weekly weight chart showed the resident weighed 186.9 pounds on 3/16/10. However, following readmission to the facility the resident weighed 174.1 pounds on 4/14/10 (a 6.8% weight loss in 30 days). Review of the medical record showed no	F 274	is reported to the interdisciplinary Team, physician, the resident and the resident representative as appropriate. F) The Weight Meeting results will be reviewed at each monthly QA/QCI meeting. This is standard practice for the facility and will remain on-going.	

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F 274	Continued From page 9 evidence the interdisciplinary team had assessed the changes in the resident's condition to determine whether or not a significant change MDS assessment should be conducted. Interview with the MDS coordinator on 2/8/11 at 5:20 PM confirmed the facility had not completed a significant change MDS after the resident's return from the hospital. Interview with the MDS coordinator on 2/16/11 at 1:45 PM revealed the facility thought the weight loss was due "in part" to the resident's edema. Review of the "Daily Skilled Nurse's Notes" showed the resident had 2+ edema prior to his/her hospitalization. Edema was noted on 4/14 and 4/15 but not rated. In addition, the MDS coordinator stated the resident was "overweight" at the time of her admission; therefore, the facility was not concerned about the significant weight loss. According to the Centers for Medicare and Medicaid Services: Long-term Care Facility Resident Assessment Instrument User's Manual, December 2002, revised December 2008: A "significant change" is a decline or improvement in a resident's status that: 1) Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention, is not "self-limiting" 2) Impacts more than one area of the resident's health status; and, 3) Requires interdisciplinary review and/or revision of the care plan.	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 10 Based on observation, staff interview and review of the facility's policies and procedures, the facility failed to ensure 1 of 3 medication carts was secured to prevent unauthorized entry. The findings were: During an observation on 2/8/11 at 5:50 PM medication cart #2 was found unattended and unlocked at the nurses' station. interview with the administrator at the time of the observation revealed the medication cart should have been locked. He was observed to lock the cart. The administrator also stated he would talk with the nurse responsible for leaving the cart unlocked and unattended. Review of the facility's policy and procedure entitled, "Security of Medication Cart," documented, "When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room."	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The facility will meet professional standards of quality by: A) The identified isolated incident was immediately addressed with the responsible party. B) Professional Standards In-service was conducted at the scheduled nurses meeting on February 21, 2011. C) Random audits will be conducted and reported at the QA/QCI meeting on a quarterly basis.	3/27/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance with the written plan of care for 1 of 13 sample residents (#3). The findings were: Refer to F315 for details regarding the facility's failure to check resident #3 for incontinence according to the care plan.	F 282	F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN The facility will ensure that toileting schedules for Resident #3 are consistent throughout. This will also be reviewed for all residents and the identified areas that need to be revised will be done. This will be accomplished by: A) In-service will be provided to nursing staff on March 9, 10, and 25, 2011 for scheduled toileting programs. B) Care plan revision as needed for individual residents with scheduled toileting programs. C) These interventions will be reviewed at resident quarterly MDS assessment and Care Plan meeting.	3/27/11

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F 282	Continued From page 11 Refer to F318 for details regarding the facility's failure to provide passive ROM exercises to the bilateral upper and lower extremities for resident #3 according to the care plan.	F 282	The facility will ensure that Restorative program will be delivered as recommended by facility Therapist for Resident #3 and all residents. This will be accomplished by: A) A weekly review of restorative programs with RNA, Therapy and Nursing for a 4 week time frame. B) If concerns are met within the 4 week time period, the review will be conducted monthly for a 3 month time frame. C) Continued review, after successful 3 months, will be done at quarterly Care Plan review.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assess and address potential pain associated with ROM exercises for 1 non- sample resident (#37) who received restorative ROM. The findings were: Observation on 2/7/11 at 3:58 PM revealed resident #37 had his/her left hand covered with an ace wrap dressing. At that time, RN #1 stated the resident's left hand was contracted, and the clenched fingers caused a sore on the palm of his/her hand. The RN further stated that staff had applied a soft splint and wrapped the resident's hand to prevent self removal. Interview on 2/10/11 at 10 AM with CNA #2 revealed the resident usually pulled his/her hand away and physically resisted when staff attempted ROM exercises or tried to apply the hand cone. The aide also stated that staff wrapped the resident's hand to prevent him/her from removing the hand cone.	F 309	P309 **483.25 PROVIDE CARE/SERVICE FOR HIGHEST WELL BEING** The facility will ensure that residents exhibiting s/s of pain when in active therapies will receive a pain assessment from Charge Nurse and medication if indicated by physician's order. This will be accomplished by: A) Resident #37 has been prescribed routine pain medication 30 minutes prior to placement of the anti-contracture device. This was requested ordered by the physician on February 11, 2011. B) Weekly review of RNA program will be conducted by Restorative Nurse. B) Restorative Nurse will identify concerns with the DON on a weekly basis for a 30 day time frame. D) If situation is resolved within that 4 week time frame, the review will be done monthly for a 3 month time frame. E) Upon the success of the monthly reviews, this will then be done quarterly and reported quarterly to the QA/QCI committee. F) Restorative Nursing Program Review form will be used to provide information to DON and QA/QCI committee.	3/27/11

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F 309	Continued From page 12 Review of the 10/24/10 quarterly MDS assessment for the resident revealed s/he had cognitive impairment, resistive behaviors, and functional limitation in ROM in one upper extremity. Review of the current care plan for the resident showed s/he was at risk for altered comfort/pain, and the interventions for this risk included; administer medication as ordered, position for comfort and monitor for signs and symptoms of contracture formation. Review of the October 2010 through February 2011 Restorative Care Flow Records showed staff were to apply a splint to the resident's left hand at least every two hours daily and perform passive ROM twenty times a month. Review of the restorative care progress notes showed the following documentation: On 10/1/10 the resident refused, ... "hand contracture seems to be getting worse and worse, very hard to get brace on hand." On 10/4/10 the resident still refusing, cooperates "until fingers have to be" pulled "more than an inch from palm of hand states pain is too much and becomes non-compliant." Further review of the documentation in the restorative progress notes showed the resident "refused" the passive ROM and/or splint twelve times in November 2010, fourteen times in December and twelve times in January 2011. Review of documentation in the 2/7/11 physician's order form showed "left hand is very contracted"..."has lesion area to left palm"...treatment started "cleanse with Bacitricin and cover with a dressing every day"...until healed. Review of the 10/11/10 rehabilitation screening completed by COTA #1 showed the resident had discomfort with ROM. However, review of the 1/13/11 screening by the same COTA showed the resident's discomfort with ROM had progressed to "extreme." Interview with the DON on 2/10/11 at 2:15 PM	F 309		

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F 309	Continued From page 13 revealed that, due to cognitive impairment, it was difficult to determine the cause of the resident's refusals and staff had not considered pain as a factor. She stated the pain assessments for the resident showed s/he did not have pain, but these assessments did not include a thorough assessment of pain as it related to ROM exercises. She further stated the resident did not have any pain medications ordered and nursing staff had not talked with the occupational therapy staff about modalities for pain prior to exercise. Interview on 2/16/11 at 9:25 AM with COTA #1 revealed, due to cognitive impairment, it sometimes appeared that the ROM caused the resident pain; and other times it did not.	F 309		
F 315 S=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide services to keep residents as dry as possible for 1 of 10 sample residents (#3) who were incontinent. The findings were: Review of the 12/27/10 quarterly MDS	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER The facility will ensure that toileting schedules are observed for Resident #3 and all residents. This will be accomplished by: A) In-service will be provided to nursing staff on March 9, 10, and 25, 2011 for scheduled toileting programs. B) Care plan revision as needed for individual residents with scheduled toileting programs. C) These interventions will be reviewed at resident quarterly MDS assessment and Care Plan meeting. D) QA/QCI team will be kept apprised of the progress of these reviews on a monthly basis at the monthly QA/QCI meeting.	3/27/11

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F 315	Continued From page 14 assessment showed resident #3 was completely incontinent of bladder. Review of the 1/11 care plan showed staff were to check and change the resident every two hours during the day. During an observation on 2/8/11 from 7 AM through 9:55 AM (2 hours and 55 minutes), the resident was not checked for incontinence. At 9:55 AM, CNA #1 changed the resident. The resident's brief was saturated with urine at that time, and the cloth pad beneath the resident was saturated with urine and had a noticeable brown stain ring. The odor of stale urine was apparent at the time. The adult brief was marked as 2/8/11 at 4:50 AM for the last change (5 hours and 5 minutes). During an interview with the aide immediately after the observation, she stated she checked the resident before breakfast and became busy with other tasks afterward and just forgot.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 7 sample residents (#3) with a decline in ROM received adequate restorative services. The findings were: Review of the 12/27/10 quarterly MDS	F 318	F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION The facility will ensure that Restorative program will be delivered as recommended by facility Therapist for Resident #3 and all residents. This will be accomplished by: A) A weekly review of restorative programs with RNA, Therapy and Nursing for a 4 week time frame. B) If concerns are met within the 4 week time period, the review will be conducted monthly for a 3 month time frame. C) Continued review, after successful 3 months, will be done at quarterly Care Plan review. D) QA/QCI team will be kept apprised of the progress of these reviews on a monthly basis at the monthly QA/QCI meeting.	3/27/11

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F 318	Continued From page 15	F 318		

assessment showed resident #3 had ROM impairment to upper and lower extremities on both sides. Further review of the medical record showed the resident had decorticate posturing of all extremities (involuntary flexion of upper extremities, involuntary extension of lower extremities) as a result of a severe head injury and was in a chronic vegetative state. Review of a 7/28/10 physician's order showed the resident was to receive passive ROM exercises from the restorative program five times a week for passive ROM to ankles, forefeet, and toes bilaterally. Review of the Restorative Care Flow Records revealed the following concerns:

a. Review of the August 2010 Restorative Care Flow Record showed the resident received passive ROM three times from the 8th through the 14th, four times from the 15th through the 21st, three times from the 22nd through the 28th, and once on the 30th.

b. Review of the September 2010 Restorative Care Flow Record showed the resident received passive ROM four times from the 1st through the 7th, three times from the 8th through the 14th, one time from the 15th through the 21st, three times from the 22nd through the 28th, and on the 29th and 30th.

c. Review of the October 2010 Restorative Care Flow Record showed the resident received passive ROM four times from the 15th through the 21st, and three times from the 22nd through the 28th.

d. Review of the November 2010 Restorative Care Flow Record showed the resident received passive ROM three times from the 1st through the 7th, four times from the 8th through the 14th, four times from the 15th through the 21st, three times from the 22nd through the 28th, and on the

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F 318	Continued From page 16 29th. e. Review of the December 2010 Restorative Care Flow Record showed the resident did not receive passive ROM from the 12/1/10 through the 12/7/10, two times from the 12/8/10 through the 12/14/10, three times from the 12/22/10 through the 12/28/10, and did not received passive ROM at any time on 12/29/10 or 12/30/10. Interview with the restorative coordinator on 2/9/11 at 9:35 AM, revealed the resident did not always get passive ROM exercises as ordered because the one person contracted to perform passive ROM was not always available five times a week.	F 318		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS This facility will ensure that each resident's medication regime will be free from unnecessary medications. A) Nursing staff will be in-serviced on appropriate interventions prior to administration of hypnotics. This will be completed by March 25, 2011. B) Compliance will be audited by DON or designee weekly for a 4 week time frame. C) If compliance is successful, the audit will be done monthly for 3 months. D) If compliance is successful, the audit will be completed quarterly with Care Plan review. E) Per MDS requirement, a sleep assessment is completed upon admission and at quarterly review of MDS. F) Resident #45 has had the sleep assessment completed as per the MDS requirement. Currently a sleep pattern review is being done for all residents (inclusive of #45) who are prescribed a hypnotic for sleep disturbances. G) QA/QCI team will be kept aware of the progress of these audits during their monthly meeting.	3/27/11

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THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD 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 329	Continued From page 17 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 1 of 12 sample residents (#45). The findings were: Review of the medical record for resident #45 showed s/he had a 12/14/10 physician's order for temazepam 7.5 mg (hypnotic) each night for sleep. Review of the resident's December 2010, January 2011, and February 2011 MARs showed s/he received the medication each night. Further review showed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance, or that other non-pharmacological interventions were tried. Interview with the DON on 2/9/11 at 12:30 PM revealed the resident did not have an assessment for sleep issues. According to the 11th edition of Lexi-Comp's 2010 Drug Information Handbook for Nursing, temazepam is for short-term treatment of insomnia.	F 329		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced	F 468		

3/24/11

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

PRINTED: 02/25/2011
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
	535051	A. BUILDING _____ B. WING _____	C 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 468	Continued From page 18 by: Based on observation and staff interview, the facility failed to securely attach a seventy-eight inch handrail to the wall in 1 of 4 resident accessible hallways. The findings were: During an observation on 2/10/11 at 10:15 AM, a handrail that was 78-inches in length and located in the secure unit outside of room #21 was noted to be loosely attached to the wall. The rail became detached on the left side upon the application of slight pressure. Immediately after the observation, the maintenance director was shown the handrail. During an interview at that time, the maintenance director stated that the handrail attachment was broken on the under part of the left side. He further stated that the handrail should support the weight of an adult without difficulty.	F 468	F468 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility will ensure that all handrails are securely fastened. A) Repair of the handrail has been accomplished as of 3/21/2011. This was done by reinforcing the broken handrail and rebolting to the wall to insure strength of the handrail. B) Administrator and/or designee will conduct hands-on inspection of handrails on a weekly basis for a 4 week time frame. C) This will, if no concerns are noted within the 4 week time frame, then be done on the monthly maintenance rounds. D) Maintenance/Housekeeping Department Managers will report at the monthly QA/QCI meeting the weekly/monthly inspection reports.	3/27/11

3/24/11