PRINTED: 03/26/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	532651	A. BUILDING 01 - MAIN BUILDING B. WING	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1525 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
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) with plan approval in 1967 and 1972. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility has a capacity of 60 certified medicare and medicaid beds.	K 000	Preparation and execution of this 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 statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all smoke barriers were maintained as a continuous membrane in 1 of 4 smoke compartments. The findings were; Observation on 3/15/12 between 11 AM and 3:30 PM revealed the following concerns: a. Three heating light bulbs were missing from a ceiling heating lamp in soiled linen room #3. Three pieces of aluminum foil were used to replace the light bulbs. b. A bed frame had punched a 3 inch circular	K 012	The facility will ensure walls and ceilings are smoke resistant in all 4 smoke compartments. This will be accomplished by: A) The fixture cover will be removed and hole will be sheet rocked, taped and painted appropriately. B & C) The hole in Resident Room #7 and the business office will be taped and painted appropriately. Monitoring: It is the responsibility of the Maintenance Director to monitor issue	4-29-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter Small, NHA — TITLE: — (X6) DATE: April 4, 2012

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.

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: HK831 — Facility ID: WY0105 — If continuation sheet Page 1 of 8

Approved without need for any changes 4/6/12 @ 1:48 pm - Sec notified Admin via phone — SG

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING 02 - MAIN BUILDING B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1328 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
K 012	Continued From page 1 hole in the wall in resident room #7. c. A two-inch round hole in the wall was noted behind the door in the business office. d. The administrator and maintenance manager verified these findings at the times of the observations. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor. Such firestopping shall consist of wood not less than 2 in. (5 cm) (nominal) thick or shall be of noncombustible material. 19.3.6.2.2* Corridor walls and ceilings shall form a barrier to limit the transfer of smoke.	K 012	for compliance to insure facility smoke barriers are maintained. Quality Assurance: Maintenance Director will report results of the monitoring monthly at QA meeting. Appropriate follow-up actions will be implemented by the QA committee.	4-29-12
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The facility will ensure corridor doors are smoke resistant to the passage of smoke in all 4 compartments. This will be accomplished by: A) The corridor doors to Resident Rooms #34 & # 37 were adjusted on 3/16/2012 to close completely in frames utilizing 5 or less foot pounds of pressure. B) The privacy curtains in Rooms #30 and #34 were attached on 3/16/2012 to a Velcro strip on the bed foot boards to allow doors to close.	

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

PRINTED: 03/29/2012
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 02 - MAIN BUILDING B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 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
K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 4 corridor doors were resistant to the passage of smoke in 2 of 4 smoke compartments. The findings were: Observation on 3/15/12 between 11 AM and 3:30 PM revealed the following concerns: a. The corridor doors to resident rooms #34 and #7 did not close completely in the frames unless force in excess of 5 foot pounds of pressure was applied. b. Privacy curtains hanging near the doors in resident rooms #30 and #34 prevented the corridor doors from closing. c. The maintenance manager verified the above findings at the times of the observations. Ref: 2000 NFPA 101 Life Safety Code. Section 19.3.6.3.2 Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 ft-lb is applied at the latch edge of the door. Section 19.3.6.3.1. Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting	K 018	Monitoring: Maintenance Director will monitor monthly to ensure facility corridor doors are resistant to the passage of smoke. Quality Assurance: Maintenance Director will report results of monitoring monthly at QA meeting. Appropriate follow-up actions will be implemented by the QA committee.	4/29/12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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

PRINTED: 03/29/2012
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 02 - MAIN BUILDING B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 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
K 038	Continued From page 3 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure facility property exit access was unobstructed in 2 of 2 fence exits. The findings were: Observation on 3/1512 at 12:48 PM revealed keys to gates in the facility perimeter fence were hanging on the outside of the fence (alley side) in line with facility emergency exits near resident rooms #9 and #15. The keys were capable of locking the gates from the alley side preventing the gates from being opened from the inside of the facility compound enclosure. Interview with the administrator and maintenance manager at the time of the observation confirmed the findings. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.2.1: 7.1.10.1 Means of egress shall abe continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038	The facility will ensure that exit access is arranged so that exits are readily accessible at all times. This will be accomplished by: Deficiency repairs were completed on 3/14/12 to comply with the Life Safety Code. The Administrator and Maintenance Director immediately removed the keys hanging on the outside of the fence (alley side) in line with facility exits near Resident Rooms #9 & #15. The gates can now be opened from both sides. <u>Monitoring:</u> Maintenance Director will monitor monthly to ensure facility property exit accesses are unobstructed. <u>Quality Assurance:</u> Maintenance Director will report results of monitoring monthly at QA meeting. Appropriate follow-up actions will be initiated by the QA committee.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	The facility will ensure the sprinkler systems are continuously maintained and in reliable operating condition and	4-29-12

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

PRINTED: 03/29/2012
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 02 - MAIN BUILDING B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 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
K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to test the sprinkler system as required. The findings were: On /15/12 at 2:48 PM the facility could not produce the quarterly water main drain testing records for the second, third and fourth quarters of 2011. The maintenance manager and the administrator acknowledged the finding when the deficiency was identified. Ref: 2000 NFPA 101 Section 19.3.5.1 (existing). Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. 9.7.5 All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested and maintained in accordance with NFPA 25.	K 062	are inspected and tested periodically. This was accomplished on 3/26/2012. The Maintenance Director is responsible for the main drain testing procedure and record keeping for the quarterly main drain test. Monitoring: The Maintenance Director will monitor monthly to ensure regular sprinkler test is performed on a timely basis. Quality Assurance: Maintenance Director will report results of monitoring quarterly or more frequently as needed at the QA meetings for review. Appropriate follow-up actions will be initiated by the QA committee.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with the National Electric Code in 1 of 4 smoke compartments. The findings were: Observation on 3/15/12 at 1:48 PM revealed a	K 147	The facility will ensure that electrical systems are properly maintained. This will be accomplished by: A) The second surge protector was removed on 3/22/12.	4-29-12

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING 02 - MAIN BUILDING B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 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
K 147	Continued From page 5 surge protector was plugged into another surge protector in the business office. Interview with the administrator and maintenance manager at the time of the observation confirmed the above findings. Reference: NFPA 70, National Electrical Code, 1999 Edition. Article 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure.	K 147	Monitoring: Maintenance Director will monitor monthly to insure electrical system is properly maintained. Quality Assurance: Maintenance Director will report results of monitoring quarterly or more frequently as needed at the QA meetings for review. Appropriate follow-up actions will be initiated by the QA committee.	