PRINTED: 05/17/2013
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
	560061	A. BUILDING _____ B. WING _____	R-C 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1326 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 On 5/14/13 an onsite follow-up was conducted for the 3/28/13 recertification survey. At this same time, complaint # WY...1622 was also investigated. No deficient practice was identified related to the allegations in the complaint. The following common abbreviations are used throughout this document: CAA: Care Area Assessments DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse	{F 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.	
{F 273} 36=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive MDS assessment for 1 of 1 newly admitted resident (#4). The findings were: Resident #4 was admitted to the facility on 4/24/13. The following concerns with timely assessment were identified:	{F 273}	Resident #4 MDS's are current. The facility ensures that comprehensive MDS's are completed within 14 calendar days after admission. To be completed by DNS/designee. The MDS coordinator will be in-serviced on the importance of the timely completion of MDS assessments within 14 calendar days after admission. To be completed by the DNS/designee. Audits on the next 5 admissions will be conducted.	~~6-28-13~~ 6/6/13 SH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Walter Small, NHA	Administrator	May 22, 2013

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. POC accepted. Case to Bevan Bolden, DON on 5/23/13 @ 4:05 pm.

Jacelle Cain 10281C

6/3/13 9:05 AM Walter Small administrator requested POC dates to be changed to 6/6/13. Changes accepted/approved - SHudson MSc RQAS

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	535051	A. BUILDING _____ B. WING _____	R-0 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1326 THERMOPOLIS, WY 82443

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{F 279}	Continued From page 1 a. Review of the resident's admission MDS assessment on 5/14/13, (20 days after admission), showed MDS item Z0500 was not signed by the RN Assessment Coordinator, verifying the assessment was complete. b. During an interview with the DON on 5/14/13 at 11:45 AM, she acknowledged the assessment was late. According to the Resident Assessment Instrument (RAI) (V1.08) version 3.0, the assessment completion is required within 14 calendar days of admission and the assessment completion is "defined as completion of the CAA process in addition to the MDS items, meaning the RN assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations."	{F 279}	Audit findings to QA.	
{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: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were completed in accordance with professional standards for 1 of 1 newly admitted resident (#4). The findings were: Review of the medical record showed resident #4 was admitted to the facility on 4/24/13. Review of the admission MDS assessment revealed the CAAs were documented as completed on 5/14/13 by an LPN and not the RN.	{F 281}	The facility ensures that all CAA assessments are completed and signed by an RN according to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, chapter 9 Delegation and Assignment, page 9-4; section 7. The MDS coordinator and DNS will be in-serviced on the importance of having an RN complete the CAA to comply with the Wyoming Nurse	6-28-13 6/6/13

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	535061	A. BUILDING _____ B. WING _____	R-C 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1828 THERMOPOLIS, WY 82443

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{F 281}	Continued From page 2 During an interview with the DON on 5/14/13 at 11:45 AM, she acknowledged the LPN had signed for the completion of the nursing CAAs on that date. According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-5, (i) The registered professional nurse: (A) Conducts a comprehensive health assessment that is an extensive data collection (initial and ongoing) regarding individuals, families, groups, and communities. (ii) "Validating, refining, and modifying the data..." (B) Establishes and documents the nursing diagnosis which serves as the basis for the plan of care. According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-6 (a) Standards related to the licensed practical nurse's contribution to the nursing practice: (i) The licensed practical nurse shall: (A) Contribute to the nursing assessment by: (I) Collecting, reporting, and recording objective and subjective data in an accurate and timely manner. Data collection includes observation about the condition or change in condition of the client. According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, Chapter 9 Delegation and Assignment, page 9-4; Section 7, General nursing functions and tasks that may not be delegated.	{F 281}	Practice Act. To be completed by the Administrator. An audit of 5 comprehensive assessments will be completed to ensure compliance. Audit findings to QA.	

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	530051	A. BUILDING _____ B. WING _____	R-C 05/14/2013

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
(F 281)	Continued From page 3 (a) The following nursing functions require nursing knowledge, judgement, and skill and may not be delegated: (i) The nursing process (A) Assessment; (B) Development of the nursing diagnosis; (C) Establishment of the nursing care goal; (D) Development of the nursing care plan; and, (E) Evaluation of the patient's progress, or lack of progress, toward goal achievement.	(F 281)		

Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535051	A. Building B. Wing	05/14/2013

Name of Facility	Street Address, City, State, Zip Code
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 05/12/2013	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 05/12/2013	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 05/12/2013
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 05/12/2013	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 05/12/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/12/2013
ID Prefix F0503 Reg. # 483.75(i)(1)(i-iv) LSC	Correction Completed 05/12/2013	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 05/12/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By B 5/16/13	Date:	Signature of Surveyor: RaeAnne White		Date: 5-15-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:		

Followup to Survey Completed on: 03/28/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO