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

PRINTED: 04/26/2016
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	04/19/2016

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 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, 1 story building of Type V (000) construction built in 1954 with additions of the same construction type built in 1985 and 1990. The building was equipped with a supervised, automatic wet sprinkler system and a zoned fire alarm system. The facility has a capacity of 60 certified Medicare and Medicaid beds with a census of 46.	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 the deficiencies. The plan of correction is prepared and/or 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 taken.	6/5/16
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily 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 arrange exit access so that exits are readily accessible at all times in 2 of 4 smoke compartments. The findings were: 1. Observation on 04/19/16 from 1:45 PM to 3:25 PM of the doors in the following locations revealed the doors required tight pinching, and more than one releasing operation to make the doors operable. Room #3, MDS office, shower room #45, shower room adjacent to room #7, room #14, rack room, and the boiler room. At the time of the observations the Facility Maintenance Manager acknowledged the door locks required more than one releasing operation.	K 038	1. The facility will ensure that all exit access is arranged so that exits are readily available in accordance with 7.1 and 19.2.1. 2. All residents are affected. 3. The facility will install door handles that are not tight pinching and that have more than one releasing operation on all 7 doors cited. The facility permanently disabled keyed locks on all courtyard doors cited on 4/20/16. Maintenance staff will be in-serviced on sections 7.1 and 19.2.1 that all exit access is arranged so that exits are readily available. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Finding to QA monthly. 5. Compliance date: June 5, 2016	DS 5/13/16

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

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 ViA Phone Call with Administrator Toivo Homi on 5/16/16 @ 9:32 AM. 34354

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X8) DATE

Toivo Howi — Administrator — 5/18/16

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.

RECEIVED
MAY 18 2016
Healthcare Licensing and Surveys

PoC accepted via phone call from Jeff Shulman on 5/16/16. Tobu

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K 038	Continued From page 1 2. Observation on 04/19/16 at 2:12 PM and 3:12 PM of the B hallway courtyard and the dining room courtyard revealed both gates were equipped with a keyed lock. At the time of the observations the gates were not locked. Interview with the Facility Maintenance Manager confirmed that the gates are locked on occasion. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038		6/5/16
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10 in 2 of 4 smoke compartments. The findings were: Observation on 04/19/16 from 1:50 PM to 2:16 PM revealed fire extinguisher's mounted on the wall with the top of the fire extinguisher approximately 66 inches from the floor in the following locations. Fire extinguisher adjacent to room #2, B hall fire extinguisher, and the main hall fire extinguisher. At the time of the observations the Facility Maintenance Manger acknowledge the height of the extinguishers. Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1998 NFPA 10, Section 1-6.10	K 064	1. The facility will ensure that all portable fire extinguishers are installed, inspected and maintained in accordance with 9.7.4.1, NFPA 10 in 4 of 4 smoke compartments. 2. All residents are affected. 3. All portable fire extinguishers cited were lowered to be no more than 60 inches from the floor on 4/20/16. Maintenance staff will be in-serviced on section 9.7.4.1, NFPA 10 that all portable fire extinguishers shall be installed, inspected and maintained in all health care occupancies. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Finding to QA monthly. 5. Compliance date: June 5, 2016	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		6/5/16

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K 147 SS=D	Continued From page 2 Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical wiring and equipment in accordance with NFPA 70 in 1 of 4 smoke compartments. The findings were: Observation on 04/19/16 at 2:20 PM revealed an outlet in room #12 with a broken face plate. At the time of the observation the Facility Maintenance Manager acknowledged the outlet. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.2 1999 NFPA 70, Article 370-25	K 147	1. The facility will ensure that all electrical and wiring equipment is in accordance with National Electrical Code, 9-1.2 (NFPA 99) 18.9.1 and 19.9.1. 2. All residents are affected. 3. The outlet in room #12 with a broken face plate was repaired on 4/20/16. Maintenance staff will be in-serviced that all electrical wiring and equipment be in accordance with NFPA 70 in 4 of 4 smoke compartments as well as National Electrical Code, 9-1.2 (NFPA 99) 18.9.1 and 19.9.1.	