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

PRINTED: 06/07/2016
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 _____ B. WING _____	04/21/2016

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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set mg- milligrams Less commonly used abbreviations will be annotated in each deficiency.	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 the deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of the 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.	
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 3 of 3 resident units (unit 1, unit 2, secure unit). The findings were: 1. Observation on 4/19/16 at 9:55 AM showed 5 tiles that measured 8 inches by 8 inches outside room #26 that were chipped or cracked and	F 253	1. The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 2. All residents are affected. 3. The following tiles will be replaced: 5 8X8" tiles outside of room #26, 4 7X12"	6/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Adams — TITLE: Administrator — (X6) DATE: 05/16/2016

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.

Approved on 6/20/16 by Lori Russ 6/20 323

originally accepted 5/16/16 by Lori Russ

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F 253	Continued From page 1 visibly dirty with an uncleanable surface. 2. Observation on 4/20/16 at 4:59 PM showed 4 tiles that measured 7 inches by 12 inches and 1 tile that measure 12 inches by 12 inches outside the "wet room" that were chipped or cracked and visibly dirty with an uncleanable surface. 3. Observation on 4/20/16 at 5:14 PM showed 6 tiles that measured 9 inches by 9 inches outside of room #17 that were chipped or cracked and visibly dirty with an uncleanable surface. 4. Observation on 4/20/16 at 5:22 PM showed 6 tiles that measured 12 inches by 12 inches outside of room 31 that were chipped or cracked and visibly dirty with an uncleanable surface. 5. Observation on 4/20/16 at 5:23 PM showed a corner at the base of the half wall in the "shower room" with an area that measured 3 inches by 3 1/2 inches where the tile had broken off and exposed the underlying surface and was visibly dirty with an uncleanable surface. In addition, a base board was not secured to the wall. Further, there was a gouge that measured 2 1/2 inches by 1/2 inch that was 33 3/4 inches up from the floor, which exposed the underlying surface and was visibly dirty with an uncleanable surface. 6. Observation on 4/20/16 at 5:02 PM showed the entry door to room #8 had a gouge 3 inches up from the bottom that spanned the width of the door. The gouge had removed the finish and exposed the wood. 7. Observation on 4/20/16 at 5:05 PM showed the entry door to the "shower room" had a gouge 3 inches up from the bottom that spanned the width	F 253	and 1 12X12" tiles outside "wet room," 6 9X9" tiles outside room #17 and 6 12X12" tiles outside room #31. In the shower room broken tiles will be replaced, the gouge in the wall will be repaired and the baseboard will be secured to the wall. The following kick-plates will be replaced: entry door to room #8, bathroom door in room #16 and the entry door to room #19. Maintenance/Housekeeping staff will be in-serviced on CFR 483.15(h)(2) that the facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 4. Director of Maintenance/designee will monitor per the facility PM guide monthly. Finding to QA monthly. 5. Compliance date: June 5, 2016	

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F 253	Continued From page 2 of the door. The gouge had removed the finish and exposed the wood. 8. Observation on 4/20/16 at 5:16 PM showed the bathroom door of room #16 had a gouge 3 inches up from the bottom and a gouge 8 inches up from the bottom that spanned the width of the door. The gouges had removed the finish and exposed the wood. 9. Observation on 4/20/16 at 5:23 PM showed the entry door to room #19 had a gouge 3 inches up from the bottom that was 12 inches wide. The gouge had removed the finish and exposed the wood. 10. Interview with the maintenance director on 4/21/16 at 9:18 AM revealed he was aware of some of the areas and he had a plan to fix them, but nothing in writing. Further, it was confirmed that the facility could not effectively clean the broken tiles or the gouges in the doors.	F 253		
F 273 SS=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 medical record review and staff	F 273	1. Resident #22 Initial MDS was	6/5/16

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F 273	Continued From page 3 interview, the facility failed to ensure the initial MDS assessment was completed within 14 calendar days of admission for 1 of 5 sample residents (#22) whose initial MDS assessment was reviewed. The findings were: Review of the medical record showed resident #22 was admitted on 3/28/16. On 4/19/16 at 4 PM the initial MDS assessment was requested for review, but nurse manager #1 stated the MDS assessment was not completed. The initial MDS assessment was provided on 4/20/16. Review of the assessment showed it was completed on 4/19/16 (day 23). During an interview on 4/20/16 at 12:09 PM nurse manager #1 stated the facility had been having a hard time getting assessment done on time.	F 273	completed. 2. All new admissions to the facility are affected. 3. The facility ensures that all New Admissions Comprehensive Assessments will be completed within the 14 day required time frame. The MDS Coordinator will be in-serviced on the importance of completing a Comprehensive Assessment of a resident within 14 calendar days of admission. 4. The DNS or designee will audit all admissions each week x 90 days to ensure that all Comprehensive Assessments are completed on time. Audit findings will be reviewed at monthly QA meetings. 5. Compliance Date June 05, 2016	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a comprehensive assessment not less than every 12 months for 1 of 4 sample residents (#30) who had an annual MDS assessment completed. The findings were:	F 275	1. Resident #30 CAAs were completed. 2. All residents are affected. 3. The facility ensures that a comprehensive assessment will be	6/5/16

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F 275	Continued From page 4 Review of the medical record showed resident #30 had an annual MDS assessment with an Assessment Reference Date (ARD) of 11/25/14. Review of the subsequent annual MDS assessment showed an ARD of 11/22/15. However, further review of the assessment showed section V of the assessment and the Care Area Assessments (CAAs) were not completed/dated until 2/10/16. During an interview on 4/20/16 at 12:09 PM nurse manager #1 stated the assessment had not been completed until 2/10/16. She stated the facility had been having a hard time completing assessments in a timely manner.	F 275	completed every 12 months. The MDS Coordinator/Designated RN/DNS responsible for completing annual MDS assessments and the Care Area Assessments will be in-serviced on the importance of completing Assessments and CAAs in the required time frame of not less than once every 12 Months. 4. The DNS or designee will audit all scheduled comprehensive assessments each week x 90 days to ensure that all assessments and CAAs are completed on time. Audit findings will be reviewed at monthly QA meeting. 5. Compliance Date: June 05, 2016	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		6/5/16

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F 279	Continued From page 5 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, review of policies, medical record review and staff interview, the facility failed to develop an individualized care plan to meet the needs of 3 of 11 sample residents (#13, #22, #43). The findings were: 1. Review of the 4/19/16 initial MDS assessment revealed resident #22 was frequently incontinent of bladder and was on a toileting program. Observation on 4/19/16 from 8 AM until 12:17 PM (4 hours 17 minutes) revealed the resident was not offered the bathroom nor checked for incontinence. Review of the care plan for incontinence (initiated 4/1/16) showed staff were instructed to assist the resident to toilet upon rising, before and/or after meals, at bedtime and as needed during the day/evening. The care plan lacked individualized toileting times based on the resident's voiding pattern or more specific timeframes to ensure the resident remained as dry as possible. 2. Medical record review showed resident #43 had diagnoses which included non-Alzheimer's dementia. Review of the 10/7/15 annual MDS assessment showed the resident was always incontinent of urine and required limited assistance from one staff member for toileting. Observation on 4/19/16 from 8:05 AM through 11:30 AM (3 hours and 25 minutes) showed staff failed to ask the resident if s/he needed to toilet, and staff failed to check the resident for incontinence. Observation on 4/19/16 at 11:30	F 279	1. Resident #13 Has been placed on a bowel and bladder tracking. Care plan to be revised based on individual voiding pattern. Resident #22 has been placed on a bowel and bladder tracking. Care plan to be revised based on individual voiding pattern. Resident #43 Has been placed on a bowel and bladder tracking. Care Plan to be revised based on individual voiding pattern. 2. All residents are affected 3. The facility ensures that comprehensive care plans are individualized and are developed to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The MDS Coordinator and Licensed Staff will be in-services on the importance of developing an individualized comprehensive care plan that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 4. The DNS or designee will audit 3 care plans each week to ensure that the care plans individualized based on unique voiding patterns of each resident. Audit findings will be reviewed at monthly QA	

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F 279	Continued From page 6 AM showed restorative aide #1 assisted the resident to the toilet. At that time the resident was observed to have been incontinent of urine, which was confirmed by the restorative aide. The care plan stated the following concerning toileting assistance: "Assist to toilet on rounds and PRN [as needed] at NOC [nighttime]. Assist to toilet upon rising/before &/or after meals at HS and PRN during the day...Provide pericare after each episode of incontinence." The following concerns were identified: a. The care plan failed to address individual requirements to take into account the resident's unique voiding pattern. The plan also failed to specify a timeframe to check the resident for incontinence that would ensure the resident remained reasonably dry and clean in order to lessen the risk of issues such as skin breakdown. b. Interview with the DON and nurse manager #1 on 4/21/16 at 8:45 AM confirmed the care plan was not individualized. 3. Medical record review showed resident #13 had diagnoses which included non-Alzheimer's dementia and chronic kidney disease. Review of the 2/7/16 quarterly MDS assessment showed the resident was occasionally incontinent of urine, was on a toileting program or trial, and required extensive assistance from one staff member for toileting. Observation on 4/19/16 from 8:15 AM through 12:07 PM (3 hours and 52 minutes) showed staff failed to ask the resident if s/he needed to toilet, and staff failed to check the resident for incontinence. Observation on 4/19/16 at 12:07 PM showed CNA #1 assisted the resident to the toilet. At that time the resident was observed to have been incontinent of urine, which was confirmed by the CNA. The care plan stated the following concerning toileting assistance:	F 279	meetings. 5. Compliance Date: June 05, 2016	

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F 279	Continued From page 7 "Assist to toilet on rounds and PRN [as needed] at NOC [nighttime] as [s/he] permits. Check and change on rounds and PRN at NOC. Assist to toilet upon rising, before &/or after meals at HS and PRN during the day/eve as [s/he] permits." The following concerns were identified: a. The plan failed to address the resident's specific voiding pattern and lacked more specific timeframes to ensure the resident was as continent as possible. b. Interview with the DON and nurse manager #1 on 4/21/16 at 8:47 AM confirmed the care plan was not individualized. 4. Review of the care plans for sample residents, including residents #13, #22, #43, revealed they all had the same toileting plan of "upon rising, before and/or after meals, at bedtime, and as needed." During an interview on 4/21/16 at 8:47 AM the DON and nurse manager #1 stated "before and/or after meals" meant staff should take the resident to the bathroom before meals; but if staff couldn't, then they should do it after the meal. When given the scenario that taking a resident before breakfast and before lunch could mean 4 hours without toileting, the DON stated "it should be more frequent than that." The DON and nurse manager #1 confirmed the toileting plans were not individualized, and were not based on the unique voiding patterns of each resident. 5. Review of the policy titled "Care Planning" received from the facility on 4/21/16 showed "...A comprehensive and individualized plan of care will be developed for each resident. The care plan will guide caregivers to assist residents to achieve or maintain their highest practical level of well being..."	F 279		

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F 280	Continued From page 8	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, policy and procedure review, and incident report review, the facility failed to ensure the care plan was updated to reflect current resident needs for 2 of 11 sample residents (#13, #33). The findings were: 1. Review of the 2/7/16 quarterly MDS assessment showed resident #13 had diagnoses that included non-Alzheimer's dementia and required extensive assistance of 1 person for transfers. Review of the "Risk for Functional/ADL	F 280	1. Resident #13 Care Plan was revised to include PRN use of the sit to stand lift. Resident #33 has expired. 2. All residents are affected. 3. The facility ensures that care plans are reviewed and updated at least quarterly and as necessary to reflect changes in the resident's status. The facility has developed a care plan input request form for nursing staff to communicate	6/5/16

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F 280	Continued From page 9 decline" care plan revised on 2/8/16 showed the resident required assistance for transfers and was able to ambulate with a front-wheeled walker. The following concerns were identified: a. Review of a nurse's note dated 2/19/16 and timed 6:13 AM showed the "resident was lowered to floor as resident slid out of 'sit-to-stand'[sic]." b. Review of a physician's record of visit dated 2/24/16 and untimed showed the reason for visit was a 60-day and increased frequency of refusal to stand when using the mechanical lift. c. Review of the incident report dated 2/22/16 and untimed showed staff felt the resident may need a "hoyer lift" [full body mechanical lift] when the resident refused to cooperate. Further, it was indicated the resident utilized a sit-to-stand lift that was approved for as-needed use by therapy. d. Interview with the DON on 4/21/16 at 8:50 AM revealed the resident did utilize the sit-to-stand lift at times and it should have been part of the care plan. 2. Review of the 3/6/16 admission MDS assessment showed resident #33 had diagnoses that included non-Alzheimer's dementia. Review of nurse's notes between 2/22/16 and 4/19/16 showed the resident had 13 falls. Further, the resident had behaviors that included agitation, physical and verbal combativeness, and exit seeking. The following concerns were identified: a. Review of nurse's note dated 3/8/16 and timed 4:11 AM showed a CNA attempted to give the resident a shower to help calm him/her down. Review of the care plan showed no evidence of showers as an intervention for behaviors. b. Review of a nurse's note dated 3/8/16 and timed 11:41 PM showed a CNA attempted to give the resident a back rub to redirect behaviors.	F 280	intervention considerations as needs arise. These are reviewed by the IDT and necessary changes made to care plans. The MDS coordinator and DNS will be in-services on the importance of timeliness of the developing a comprehensive care plan within 7 days after the completion of the comprehensive assessment as well as the importance of reviewing and updating of the care plan at least quarterly and as necessary to reflect changes in the resident's status. 4. The DNS or designee will audit 3 care plans each week x 90 days to ensure that care plans are updated to reflect current resident's needs. Audit findings will be reviewed at monthly QA meetings. 5. Compliance Date: June 05, 2016	

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F 280	Continued From page 10 Review of the care plan showed no evidence of back rubs as an intervention for behaviors. c. Review of a nurse's noted dated 3/21/16 and timed 6:36 PM showed the resident was assisted to the bathroom, then to a recliner and given a cup of coffee to watch television and relax. The intervention was noted to be effective at that time. Review of the care plan showed no evidence of this intervention for behaviors. d. Review of a nurse's note dated 3/30/16 and timed 2:38 PM showed one-on-one care was provided to the resident for safety. Review of the care plan showed no evidence of the intervention for either behaviors or falls. e. Review of nurse's note dated 4/6/16 and timed 8:45 PM showed staff used soft gentle tones to redirect the resident's behaviors. Review of the care plan showed no evidence of this intervention for behaviors or falls. f. Review of a nurse's note dated 4/8/16 and timed 1:21 AM showed the resident was moved closer to the CNA to redirect behaviors and prevent falls. Review of the care plan showed no evidence of the intervention for behaviors or falls. g. Interview with the DON on 4/21/16 at 5:50 AM revealed the facility had implemented "lots" of interventions related to falls and behaviors; however, none of them had been documented because they seemed to work for a little while and then became less effective. 3. Review of the policy titled "Care Planning" received from the facility on 4/21/16 showed "...5. The Care Plan is reviewed and updated at least quarterly and as necessary to reflect changes in the resident's status..."	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		6/5/16

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F 312	Continued From page 11 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to provide appropriate personal hygiene during perineal care for 1 of 5 sample residents (#38) observed for incontinence care. The findings were: 1. Review of the significant change MDS assessment dated 2/29/16 showed resident #38 had diagnoses that included paranoid schizophrenia and required extensive assistance of 1 person for personal hygiene. Further, the resident was determined to be always incontinent of bowel. The following concerns were identified: a. Observation on 4/19/16 at 9:50 AM showed resident #38 was taken to the shower in a wheelchair. CNAs #1 and #2 transferred the resident to the shower chair. The CNAs removed the resident's clothing and brief and found the resident had been incontinent of stool. CNA #2 provided incontinence care to the resident by wiping back and forth using the same wipe and pushing stool towards the resident's perineum. b. Interview with the DON on 4/21/16 at 8:40 AM revealed that pericare should be completed from front to back and clean to dirty. c. Review of the policy titled "Incontinence Care" received from the facility on 4/21/16 showed "Purpose: To promote cleanliness and	F 312	1. Resident #38 will receive proper incontinence care to include washing the perineum from front to back to promote cleanliness and comfort and to prevent infections, skin breakdown and body odor. 2. All residents receiving services to maintain personal hygiene are affected. 3. The facility ensures that all resident's will receive adequate incontinence care to include washing perineum from front to back to promote cleanliness and comfort and to prevent infections, skin breakdown and body odor. The nursing staff will be in-serviced on the importance of performing proper incontinence care to include washing perineum from front to back to promote cleanliness and comfort and to prevent infection, skin breakdown and body odor. 4. The DNS or designee will conduct 3 random care observations each week X 90 days to ensure proper incontinence care for dependent residents. Audit findings will be reviewed at monthly QA meetings.	

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F 312	Continued From page 12 comfort. To prevent infections, skin breakdown, and body odor...Wash perineum from front to back..."	F 312	5. Compliance Date June 05, 2016	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to implement interventions to prevent pressure ulcers for 1 of 8 sample residents (#22) who were at risk for pressure ulcers. The findings were: Review of the 4/19/16 initial MDS assessment showed resident #22 was at risk for pressure ulcers. The assessment further indicated a pressure reducing device was utilized in the bed and chair. Review of the Care Area Assessment (CAA) for pressure ulcers dated 4/19/16 showed the resident required a special mattress or seat cushion to reduce or relieve pressure. Review of the care plan for risk of pressure ulcers (initiated 4/1/16) showed interventions included "Pressure relieving/reducing devices to bed and wheelchair." The following concerns were identified:	F 314	1. Resident #22 has been provided with pressure relieving device to wheelchair. 2. All residents at risk for developing pressure ulcers are affected. 3. The facility ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable, and a resident have pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The nursing staff will be in-serviced on the importance of adhering to individualized care plans.	6/5/16

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F 314	Continued From page 13 a. Observation of the resident on 4/18/16 from 5:15 PM until 6 PM showed the resident was seated in a wheelchair without a cushion. b. Observation on 4/19/16 from 12:17 PM until 1:17 PM showed the resident was in a wheelchair without a cushion. c. Observation on 4/20/16 from 12:20 PM until 5:25 PM showed the resident was in a wheelchair without a cushion. d. During an interview on 4/21/16 at 8:47 AM the DON and nurse manager #1 stated the resident should have a cushion in the wheelchair. Nurse manager #1 stated there used to be a cushion in the wheelchair, and staff must have left it in the shower room after cleaning it.	F 314	4. The DNS or designees will conduct 3 audits each week x 90 days to ensure pressure relieving interventions are in place and adhered to per individualized comprehensive care plan intervention. Audit findings will be reviewed at monthly QA meeting. 5. Compliance Date: June 05, 2016	
F 315 SS=E	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 ensure 3 of 8 sample residents (#13, #22, #43) who required staff assistance with personal care received care in a timely manner to lessen or prevent urinary incontinence. The findings were:	F 315	1. Resident #13 will receive services in accordance with individualized plan of care. Resident #22 will receive services in accordance with individualized plan of care. Resident # 43 will receive services in accordance with individualized plan of	6/5/16

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F 315	Continued From page 14 1. Review of the 4/19/16 initial MDS assessment revealed resident #22 was frequently incontinent of bladder and was on a toileting program. Review of the "bowel and bladder report" for 4/1/16 through 4/18/16 showed the resident was documented as incontinent 18 of 20 times when "bladder occurred." The following concerns were identified: a. Observation on 4/19/16 from 8 AM until 12:17 PM (4 hours 17 minutes) revealed the resident was not offered the bathroom nor checked for incontinence. At 12:17 PM the DON woke the resident up in his/her recliner, and asked if s/he needed the restroom; the resident said no. At 12:20 PM CNA #3 came to the room to get the resident up for lunch. The resident was transferred from the recliner to the wheelchair and was taken to the dining room without the bathroom being offered, or the resident being checked for incontinence. After lunch, at 1:17 PM, the resident was taken to the restroom by CNA #3. The resident was observed to have been incontinent of bladder, which was confirmed by the CNA, and also voided in the toilet. b. Review of the care plan for incontinence (initiated 4/1/16) showed staff were instructed to assist the resident to toilet the resident upon rising, before and/or after meals, at bedtime and as needed during the day/evening. The care plan lacked individualized toileting times based on the resident's voiding pattern or more specific timeframes to ensure the resident remained as dry as possible. During an interview on 4/21/16 at 8:47 AM the DON and nurse manager #1 stated "before and/or after meals" meant staff should take the resident to the bathroom before meals; but if staff couldn't, then they should do it after the meal. When given the scenario that taking a	F 315	care. 2. All residents requiring staff assist with personal care in a timely manner to lessen or prevent urinary incontinence are affect. 3. The facility ensures that all residents requiring staff assistance with personal care will receive services in a timely manner to lessen or prevent urinary incontinence in accordance with individualized plan of care. The MDS Coordinator will be in-services on importance of individualized care plan interventions for incontinent residents. The nursing staff will be in-serviced on the importance of adhering to individualized care plans for residents incontinent of bladder to ensure they receive appropriate treatment and services to maintain and improve as much normal bladder function as possible. 4. The DNS or designee will conduct 3 random observations each week x 90 days to ensure that cares are provided according to individualized care plan. Audit findings will be reviewed at monthly QA meeting. 5. Compliance Date: June 05, 2016	

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F 315	Continued From page 15 resident before breakfast and before lunch could mean 4 hours without toileting, the DON stated "it should be more frequent than that." 2. Medical record review showed resident #13 had diagnoses which included non-Alzheimer's dementia and chronic kidney disease. Review of the 2/7/16 quarterly MDS assessment showed the resident was occasionally incontinent of urine, was on a toileting program or trial, and required extensive assistance from one staff member for toileting. Observation on 4/19/16 from 8:15 AM through 12:07 PM (3 hours and 52 minutes) showed staff failed to ask the resident if s/he needed to toilet, and staff failed to check the resident for incontinence. Observation on 4/19/16 at 12:07 PM showed CNA #1 assisted the resident to the toilet. At that time the resident was observed to have been incontinent of urine, which was confirmed by the CNA. Interview with the DON and nurse manager #1 on 4/21/16 at 4/21/16 at 8:45 AM confirmed the resident should be assisted with toileting in a timely manner, and 3 hours and 52 minutes was not timely. 3. Medical record review showed resident #43 had diagnoses which included non-Alzheimer's dementia. Review of the 10/7/15 annual MDS assessment showed the resident was always incontinent of urine and required limited assistance from one staff member for toileting. Observation on 4/19/16 from 8:05 AM through 11:30 AM (3 hours and 25 minutes) showed staff failed to ask the resident if s/he needed to toilet, and staff failed to check the resident for incontinence. Observation on 4/19/16 at 11:30 AM showed restorative aide #1 assisted the resident to the toilet at that time, and she confirmed the resident had been incontinent of	F 315		

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F 315	Continued From page 16 urine. Interview with the DON and nurse manager #1 on 4/21/16 at 8:45 AM confirmed the resident should be assisted with toileting in a timely manner, and 3 hours and 25 minutes was not timely.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure gait belts were used for 1 of 7 sample residents (#43) who were observed for assisted transfers. The findings were: 1. Review of the 8/15/15 annual MDS assessment showed resident #43 required limited assistance of one staff member for transfers. Observation on 4/19/16 at 8:25 AM showed CNA #3 transferred the resident from a recliner chair to a wheelchair. The CNA had the resident hold onto a transfer pole, then proceeded to reach under the resident's left armpit, grab his/her arm, and pull the resident upward. The resident appeared unsteady. At no time did the CNA use a gait belt for the transfer. The following concern was identified:	F 323	1. Resident #43 will receive assistance/ devices to prevent accidents in the form of gait belt use to provide safe transfer/ambulation. 2. All residents with increased risk for falls and all residents requiring assist with transfers/ambulation are affected. 3. The facility ensures that interventions are implemented/developed to prevent and minimize falls and that gait belts are used for transfers/ambulation requiring hands-on assistance to ensure the safety of residents and staff. The MDS Coordinator will be in-serviced on the importance of updating individualized care plans with interventions implemented, and documentation of recommendations	6/5/16

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F 323	Continued From page 17 a. Review of the facility policy titled, "Gait Belts" without a date, under the area titled "Purpose" showed, "To provide a safe means of transfer/ambulation for residents requiring hands-on assistance. The area titled, "Clinical Policy" showed, "To ensure the safety of our residents and staff, the use of gait belts is mandatory by all nursing personnel and rehab staff while transferring or ambulating residents." The area titled, "Procedure" showed, "...2. Gait belts will be used for transfers of residents who need the assist of 1 or 2 staff and the ambulation of residents who need an escort of 1 or 2 or who are unsteady with ambulation." b. Interview with the DON and nurse manager #1 on 4/21/16 at 8:45 AM confirmed staff were to use a gait belt for all transfers that do not require a mechanical lift for the transfer.	F 323	discussed by the IDT during post fall review. The nursing staff will be in-serviced on the importance of documenting all attempted interventions and utilization of care plan request forms. These are reviewed by the IDT. Nursing staff will be in-serviced on gait belt policy and procedure. 4. The DNS or designee will audit 3 care plans and documentation of relative IDT investigative findings each week x 90 days to ensure implementation of care plan interventions to prevent/minimize falls. The DNS or designee will conduct 3 random observations each week x 90 days to ensure safety with transfer/ambulation with use of gait belt for residents requiring assist. Audit findings will be reviewed at monthly QA meetings. 5. Compliance Date: June 05, 2016	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		6/5/16

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F 353	Continued From page 18 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility staffing, the facility failed to ensure adequate staff were assigned to provide for the physical, psychosocial, and quality of life needs for 1 of 3 resident care units (secure unit). At the time of the survey there were 15 residents on the unit. The findings were: 1. Review of the staffing schedule on 4/18/16 at 3:20 PM showed there was 1 CNA assigned to the secure unit at that time. Interview with CNA #1 on 4/18/16 at 6 PM revealed there was usually only 1 staff member on the unit and it was difficult to provide uninterrupted care and provide assistance to residents. The following concerns were identified during observations in the secure unit when there was only one staff person providing care: a. Observation on 4/18/16 at 3:48 PM showed resident #33 was propelling him/herself in a wheelchair. The resident entered another resident room and attempted to stand by using the head of the bed. The alarm, which was attached to the resident's wheelchair, sounded at that time and CNA #1 left another resident's room	F 353	1. Resident #33 has expired. 2. All residents are affected. 3. The facility ensures sufficient nursing staff to provide nursing and related serviced to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and Individual plans of care. The facility will use an acuity scale to determine licensed staff/resident ratio for the secure unit. The Administrator, DNS and MDS Coordinator will be in-services on the acuity scale tool. 4. The Administrator or designee will audit the staff to resident ratio in the secure unit, weekly x 90 days to ensure compliance with acuity scale. Audit findings will be reviewed at monthly QA meetings. 5. Compliance Date: June 05, 2016	

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F 353	Continued From page 19 to answer the alarm. The CNA assisted the resident out of the room and returned to care for the previous resident. Resident #33 again stood in the hall by using the handrail and the alarm sounded. The CNA left the other room to assist and prevent the resident from falling. Review of nurse's notes between 2/22/16 and 4/19/16 showed resident #33 had 13 falls. Further, the resident had behaviors that included agitation, physical and verbal combativeness, and exit seeking. b. Observation on 4/18/16 at 5:16 PM showed CNA #1 was passing meal trays to residents. Between trays, the CNA was providing verbal cues to other residents who had already received their meal tray. c. Observation on 4/18/16 at 5:31 PM showed CNA #1 stopped assisting a resident who required physical assistance with eating to assist a resident on the other side of the table to eat. d. Observation on 4/18/16 at 5:50 PM showed CNA #1 stopped assisting residents who required physical assistance with eating to answer the alarm of resident #33 and prevent the resident from standing without assistance. The CNA then returned to assist the residents with eating and resident #33 began running his/her wheelchair into residents in the dining room. The CNA again stopped assisting with eating and assisted resident #33 to get out of the dining area. e. Observation on 4/18/16 at 5:52 PM showed CNA #1 had to stop assisting residents to eat because another resident had spilled a drink on their meal. The CNA cleaned up the tray and requested another tray for the resident. The CNA returned to assisting the other residents to eat. The resident who received a new tray had a mechanically altered meal; however, when the	F 353		

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F 353	Continued From page 20 new tray was delivered to the resident it was a regular texture. The resident ate 6 bites of the regular meal before a dietary staff member entered the secure unit with a mechanically altered tray and the regular tray was removed. During the observation, the administrator was in the secure unit, but was not providing resident care. f. Observation on 4/19/16 at 8:20 AM showed a CNA #1 was assisting residents to eat. A resident at another table spilled his/her food on the table and continued to eat it off the table. Staff did not acknowledge the resident eating off the table. g. Observation on 4/20/16 between 4:20 PM and 4:30 PM showed there were 6 residents in the dining area unattended, and resident #33 was in the wheelchair moving throughout the hallway. During this time, CNA #1 was in a resident's room providing care. h. Observation on 4/20/16 at 4:35 PM showed there were 9 residents unattended in the dining area of the secure unit for 7 minutes while the CNA was in a resident room providing care. 2. Interview with the DON and nurse manager #1 on 4/21/16 at 8:50 AM revealed the facility had talked about increasing staffing on the secure unit, as another staff member on the secured unit would be beneficial, but they didn't have a reason why the facility had not increased the staffing.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		6/5/16

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	535051	A. BUILDING _____ B. WING _____	04/21/2016

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THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

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F 371	Continued From page 21 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in the kitchen and main dining area. The findings were: 1. Observation during the lunch food service on 4/20/16 at 11:20 AM showed the CDM wiped the main food prep table surface with a cloth from a bucket on the counter. At that time, the CDM explained the solution in the bucket was for sanitizing surfaces, and stated the solution was taken from the same solution used in the three compartment sink. Above the sink was posted instructions for the use of the Quat (ammonia based) solution, which stated the solution should be tested to pass for sanitizing at 150-400 ppm (parts per million). The following concerns were identified: a. Upon request, the CDM tested the solution in the bucket. The solution tested below 150 ppm. At that time she emptied the bucket and reconstituted the bucket according to instructions and the solution tested above 200 ppm. b. During the observation, the main food prep table was not re-wiped at any time. The facility staff proceeded to place water and coffee carafes on the table, which were filled and placed on tables in the main dining area. In addition, staff prepared other items which included frozen biscuits on the un-sanitized main food prep table.	F 371	1. The facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. 2. All residents are affected. 3. The sanitizing bucket solution will be tested and recorded at 150-400 ppm. In the event that the solution tests below or above the acceptable range, the solution will be remixed to within the acceptable range and all surfaces wiped prior will be re-wiped. Test results will be recorded. Dietary staff will be in-serviced on CFR 483.35(i) that the facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. Dietary staff will clean their hands and exposed portions of their arms after handling equipment and/or utensils before donning gloves for working with food and after engaging in other activities that contaminate the hands. Dietary staff will be in-serviced on Food Code 2013, U.S. Public Health	

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F 371	Continued From page 22 c. Review of the posted testing form showed the three compartment sink test results were routinely recorded. However, the solution in the sanitizing bucket was not recorded as tested. d. Interview with the CDM after the observation on 4/20/16 at 12:40 PM confirmed the main food prep table was not re-wiped after the solution passed the test, and the documentation failed to include testing of the solution in the bucket for sanitizing food prep areas. According to Food Code 2013, U.S. Public Health Service: 3-304.14 "...(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114..." 2. Observation during the lunch food service on 4/20/16 at 11:40 AM showed the CDM wiped a liquid solution off of the floor between the sink and main food prep table using paper towels. She did not wear gloves. The following concerns were identified: a. At that time she proceeded to take carafes of prepared water and coffee from the main prep food table and place them on a metal cart. Then she entered the main dining area and placed the carafes of water on different dining tables. She placed the carafes of coffee on a serving area with other beverages. At no time during the observation did she wash her hands. b. Interview with the CDM after the observation on 4/20/16 at 12:40 PM confirmed she had not washed her hands, and washing her hands was her expectation. According to Food Code 2013, U.S. Public Health	F 371	Service. 2-301.14 When to Wash. 4. CDM/designee will monitor sanitizing solution test results daily x 90 days. CDM will administer 1 hand washing audit randomly every week x 90 days. Findings to QA monthly. 5. Compliance date: June 5, 2016	

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F 371	Continued From page 23 Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms..."(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		6/5/16

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F 441	Continued From page 24 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control practices were implemented during 1 random observation of shower care. The practice affected 1 sample resident (#38). The findings were: 1. Observation on 4/19/16 at 9:50 AM showed resident #38 was taken to the shower in a wheelchair. CNAs #1 and #2 transferred the resident to the shower chair. The CNAs removed the resident's clothing and brief and found the resident had been incontinent of stool. CNA #2 provided incontinence care to the resident by wiping back and forth using the same wipe and pushing stool towards the resident's perineum. During the care, the resident continued to defecate and stool fell on the shower room floor. After completing the incontinence care, CNA #2 changed gloves, obtained a paper towel, and picked the stool up off of the floor to discard it in the trash can. The CNA then washed the resident's hair, face, and trunk without changing gloves. Interview with the DON on 4/21/16 at 8:40 AM revealed that staff should change gloves between clean and dirty care. Review of the policy titled "Precaution Guidelines" received from the facility on 4/21/16 showed "...Gloves...Change	F 441	1. Resident #38 will be provided a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. 2. All residents are affected. 3. The facility ensures and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The nursing staff will be in-serviced on preventing the spread of infection, use of personal protective equipment, proper peri-care technique and hand washing. 4. The DNS or designee will conduct 3 random observations each week x 90 days to ensure proper peri-care technique, glove change and hand washing. Audit findings will be reviewed at monthly QA meetings. 5. Compliance Date: June 05, 2016	

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F 441	Continued From page 25 gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms...Remove gloves promptly after use..."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medical record was complete and accurate for 1 of 12 sample residents (#12). The findings were: Review of physician orders for resident #12 showed the resident had orders for Novolog (insulin) FlexPen 100 units/milliliter three times per day before meals via a sliding scale. The sliding scale was: blood sugar less than 150: 0 units; 150-199: 1 unit; 200-249: 3 units; 250-299: 5 units; 300-349: 7 units; 350-400: 9 units. Review of the April 2016 MAR showed the	F 514	6/5/16 1. Resident #12 sliding Scale Insulin has been discontinued. 2. All residents with orders for sliding scale insulin are affected. 3. The facility ensures maintenance of clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily	6/5/16

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F 514	Continued From page 26 resident did have some blood sugars at or above 150 which required Novolog to be given. However, further review of the MAR showed no documentation of the number of units of Novolog given (the location of the injection was documented). During an interview on 4/20/16 at 9:40 AM the DON stated the lack of documentation was a computer software problem. She stated the units given used to be visible on the MAR, but for some reason, that "disappeared" in January. She showed the surveyor the MAR from December 2015 which did show the number of units given.	F 514	accessible, and systematically organized. The nursing staff will be in-serviced on maintaining clinical records and the importance of accurate documentation. 4. The DNS or designee will audit 3 Electronic Health Records with sliding scale insulin orders each week x 90 days to ensure completion and accuracy. Audit findings will be reviewed at monthly QA meeting. 5. Compliance Date: June 05, 2016.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		6/5/16

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F 520	Continued From page 27 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the CMS-2567, observation, medical record review, review of staffing schedules, and staff interview, the facility failed to have an effective quality assessment and assurance (QAA) committee to identify issues and implement action plans to correct issues and sustain compliance. The findings were: 1. Review of the prior year's survey results (CMS-2567) dated 3/26/15 revealed F315 was cited related to lack of timely services to maintain or improve bladder continence. Refer to F315 for details on lack of timely services for bladder incontinence for 3 sample residents (#13, #22, #43). During an interview on 4/21/16 at 9:36 AM the DON stated incontinence care was monitored in the QAA program after last year's survey, but the facility thought they had improved, so they quit monitoring it. She stated it was not currently being addressed in QAA. 2. Refer to F273 and F275 regarding late MDS assessments. During an interview on 4/21/16 at 9:36 AM the DON stated although the facility had identified late MDS assessments as an issue, it was not formally being monitored or addressed in the QAA program to ensure compliance. 3. Refer to F353 for details on lack of sufficient staff in the secure unit. Interview with the DON and nurse manager #1 on 4/21/16 at 8:50 AM revealed the facility had talked about increasing staffing on the secure unit, but they didn't have a	F 520	1. F315 - DNS or designee will conduct 3 random observations each week x 90 days to ensure that cares are provided according to individualized care plan. F273 - The DNS or designee will audit all admissions each week x90 days to ensure that all comprehensive assessments are completed on time. F275 - The DNS or designee will audit all scheduled comprehensive assessments each week x 90 days to ensure that all assessments and CAA's are completed on time. F353 - The Administrator or designee will audit the staff to resident ratio in the secure unit, weekly x 90 days to ensure compliance with acuity scale. Audit findings will be reviewed at monthly QA meetings. 2. All residents are affected. 3. The facility ensures it maintains a quality assessment and assurance committee consisting of the DNS, a designated physician and at least 3 other members of the facility's staff. The facility ensures it meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies.	

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F 520	Continued From page 28 reason why the facility had not increased the staffing. During an interview on 4/21/16 at 9:36 AM the DON stated that staffing on the secure unit had not been identified or addressed in the QAA program.	F 520	4. The Administrator or designee and the QA committee will review audits at monthly QA meetings and make recommendations accordingly. 5. Compliance Date: June 05, 2016.	