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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 A recertification survey was conducted by Healthcare Licensing and Surveys on 5/8/17 through 5/11/17. Complaints reviewed in the course of this survey were complaint intake WY000002371. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living RDCO: Regional Director of Clinical Services CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual	6/12/17
F 150 SS=B	483.5 DEFINITION OF FACILITY - SNF & NF As used in this subpart, the following definitions apply: Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of	F 150	1. Facility will ensure that all Resident Rights are posted, understood and enforced. 2. All residents are affected. 3. a. Facility will ensure that Resident Rights are posted in large, legible print in an easily viewable area. b. Facility will ensure that Survey Results going back 3 years will be made available at the main entrance of the facility (binder).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Toby Hamm | TITLE: Executive Director | (X6) DATE: 6-5-17

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
JUN 09 2017
Healthcare Licensing and Surveys

Spoke with executive director 6/12/17.
POC accepted with agreed upon changes.
[redacted] state surveyor

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 1 technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Common area. Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas, and meeting rooms where residents are located on a regular basis. Composite distinct part. (1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter. (2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements: (i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number. (ii) If two or more institutions (each with a distinct	F 150	c. Regional Vice President of Operations (RVOP) will in-service Executive Director on Center for Medicaere/Medicaid Services (CMS) requirements involving posting of Resident Rights and 3 years of survey results. 4. The facility will audit weekly X 90 days. Findings of audits to be brought to Quality Assurance/ Performance Improvement (QAPI) for evaluation and further educational opportunities. 5. The Executive Director (ED) is responsible for compliance. Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 2 part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care. (iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF. (iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location. (v) Use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited. Distinct part (1) Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors)	F 150		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 3 that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes composite distinct part that meets the additional requirements of this section. (2) Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements: (i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following: (A) The SNF or NF is wholly owned by the institution of which it is a distinct part. (B) The SNF or NF is subject to the by-laws and operating decisions of common governing body. (C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.	F 150		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 4 (D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services. (ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part. (iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part. (iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report. (v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF. (vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part. (B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and	F 150		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 5 cannot be made retroactive. (C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part. Exploitation. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of section s1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in §440.40 and §440.155 of this chapter), but does not include an institution for individuals with intellectual disabilities or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, and NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter. Fully sprinklered. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or	F 150		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 6 the Fire Safety Evaluation System. Licensed health professional. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician. Major modification means the modification of more than 50 percent, or more than 4,500 square feet, of the smoke compartment. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Mistreatment means inappropriate treatment or exploitation of a resident. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to	F 150		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 7 residents only as paid feeding assistants as defined in §488.301 of this chapter. Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Resident representative. For purposes of this subpart, the term resident representative means any of the following: (1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; (2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or (3) Legal representative, as used in section 712 of the Older Americans Act; or (4) The court-appointed guardian or conservator of a resident. (5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of	F 150		

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

PRINTED: 05/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 150	Continued From page 8 competent jurisdiction. Sexual abuse is non-consensual sexual contact of any type with a resident. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure residents had access to a list of resident's rights. A census of 46 residents were affected. The findings were: 1. Observation during the course of the survey failed to show resident rights information was posted in the facility. 2. Group interview on 5/9/17 at 11 AM revealed 11 out of 11 residents were not sure where resident's rights were posted within the facility. 3. Interview with the administrator on 5/10/17 at 4:30 PM revealed he had taken down the posting of the resident's rights and stated "I did not know posting resident's rights was a regulation."	F 150		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who-	F 225	1. How corrective action will be accomplished for the identified residents? No residents were identified	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 225	Continued From page 9 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 225	Graduate Nurse Aide (GNA) #1 and 2 no longer work at the facility. GNA #3 background checks and reference checks have been completed. Certified Nurse Aide (CNA) #1 background checks and reference checks have been completed 2. How you will identify other residents with the potential of being affected by the same practice? The Nursing Home Administrator (NHA)/designee will audit employee files to validate background checks and reference checks have been completed 3. Address what measures will be put in place to ensure deficient practice will not recur. EmpRes new hire policy will be followed. The ED and Business Office Manager (BOM) have been educated by RVOP on obtaining reference checks and background checks prior to having contact with residents. 4. How will the plan be monitored to ensure the solutions are sustained?	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 225	Continued From page 10 accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview the facility failed to ensure pre-hire screenings for abuse/neglect findings were completed on 4 of 5 employees (GNA #1, GNA #2, GNA #3, CNA #1) reviewed prior to resident contact. The findings were: 1. Review of the personnel file for GNA #1 showed a 3/1/17 date of hire; however there was no record of first date of resident contact and no evidence a background check or reference check had been completed. 2. Review of personnel file for GNA #2 showed a 2/6/17 date of hire; however there was no record of first date of resident contact and no evidence a background check or reference check had been completed. 3. Review of the personnel file for GNA #3	F 225	NHA/designee will audit to validate background checks and reference checks have been completed prior to resident contact x 90 days. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The administrator is responsible for compliance Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 225	Continued From page 11 showed no evidence of a date of hire or first date of resident contact. Further review revealed there was no evidence of a background check or reference check being completed. 4. Review of the personnel file for CNA #1 showed no evidence of a date of hire or first date of resident contact. Interview with business office manager on 5/11/17 at 9:00 AM revealed the CNA was hired in March 2017. 5. Interview with the administrator 5/10/17 at 5:50 PM revealed the facility's screening process for new employees included sending the information to the CNA abuse registry and department of family services (DFS), then a background check was completed. 6. Interview with business office manager on 5/11/17 at 9 AM revealed she just started in March 2017 and she didn't have evidence of background checks for current staff. She further revealed she didn't know where new employee hire documentation was located.	F 225		6/12/17
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (I)(2) 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 ensure 3 of 3 units (unit 1, unit 2, secured unit), and 1 of 2 dining rooms (main dining room) were clean and in good repair. The findings were:	F 253	1. a. 3 cracked floor tiles outside room #4 will be repaired to provide a cleanable surface. b. 4 cracked floor tiles outside room #6 will be will be repaired to provide a cleanable surface. c. 29 damaged floor tiles in room #14 ½ will be will be repaired to provide a cleanable surface.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 253	Continued From page 12 1. Observation on 5/10/17 at 2:15 PM showed the floor in front of resident room #4 had three 5 inch by 12 inch cracked tiles which created a surface that could not be cleaned effectively. 2. Observation on 5/10/17 at 2:19 PM showed the floor in front of resident room #6 had four 5 inch by 12 inch cracked tiles which created a surface that could not be cleaned effectively. 3. Observation on 5/10/17 at 2:30 PM showed the floor inside of resident room #14 1/2 had twenty-nine 12 inch by 12 inch scratched, cracked and/or chipped tiles which created a surface that could not be cleaned effectively. 4. Observation on 5/10/17 at 2:35 PM showed the door to resident room #34 contained a kick plate 34 inches by 42 1/2 inches that had a deep gouge in it which exposed the underlying material and created a surface that could not be cleaned effectively. 5. Observation on 5/10/17 at 2:36 PM showed the floor in front of the nurses' station had an area of cracked and gouged tile that measured 3/4 inch wide by 22 inches long and created a surface that could not be cleaned effectively. 6. Observation on 5/10/17 at 2:37 PM showed the outer perimeter of the tile in the dining room and hallway was discolored with a visible blackish color. 7. Observation on 5/10/17 at 2:44 PM showed the floor tile in front of the exit sign in the dining room had 15 gouges which created a surface that could not be cleaned effectively.	F 253	d. The kickplate on room #34 door will be replaced. e. Damaged floor tile outside nurse's station will be repaired to provide a cleanable surface. f. Outer perimeter of dining room flooring will be thoroughly scrubbed, cleaned and sanitized. g. The 15 gouges in the Dining room flooring in front of the exit sign will be replaced. h. The 7 damaged floor tile in the unit hallway intersection will be will be repaired to provide a cleanable surface. i. The 2 cracked floor tiles outside room #29 will be replaced. j. The Maintenance Director/designee will conduct a facility-wide ongoing floor audit to validate that floor tiles and kickplates provide a cleanable surface and that floor tiles do not contain a visible blackish color. 2. All residents are affected. 3. The maintenance director will be educated on floor tiles, kickplates and discoloration of floor tiles.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

SA 6/12/17

(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 253	Continued From page 13 8. Observation on 5/10/17 at 2:46 PM showed the floor tile in front of the secure unit had seven 9 inch by 9 inch cracked and gouged tiles which created a surface that could not be cleaned effectively. 9. Observation on 5/10/17 at 2:47 PM showed the floor tile in front of resident room #29 had two 9 inch by 9 inch cracked tiles which created a surface that could not be cleaned effectively. 10. Interview with the administrator on 5/10/17 at 3:25 PM revealed no plan was in place to replace the flooring, but it was a priority. The administrator also revealed resident room #14 1/2 used to be the physical therapy room and the floor sustained multiple cracks and gouges from the equipment.	F 253	The maintenance director will incorporate into preventive maintenance schedule; monthly inspections of floor tile, kickplates and cleanliness of floor tiles. 4. The facility will audit weekly X 90 days. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The administrator is responsible for compliance. Compliance date: June 12, 2017	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the MDS 3.0 RAI Manual, the facility failed to ensure annual assessments were completed in a timely manner for 2 of 11 sample residents (#11, #36). The findings were:	F 275	1. How corrective action will be accomplished for the identified residents? Resident # 11 and 36 have had a significant change of condition completed to initiated the Resident Assessment Instruments (RAI) process. 2. How you will identify other residents with the potential of being affected by the same practice?	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 275	Continued From page 14 1. Review of the 1/9/17 quarterly MDS assessment showed resident #11 was admitted to the facility on 4/5/16. The following concerns were identified. a. Review of the most recent comprehensive assessment showed it was an admission assessment completed on 4/27/16. b. Interview with MDS coordinator #1 and MDS coordinator #2 on 5/10/17 at 4:36 PM revealed another comprehensive assessment should have been completed; however, it had not been completed because the facility did not have enough staff at the time the assessment was due. 2. Review of the minimum data set (MDS) schedule showed resident #36 had a quarterly assessment performed with an assessment reference date (ARD) of 11/13/16, and had an admission comprehensive assessment with an ARD of 2/17/16. Interview with MDS coordinator #1 on 5/10/17 at 5:04 PM confirmed the resident had not had an MDS assessment since November 2016, and that there had not been a comprehensive assessment completed within 366 days of the prior comprehensive assessment. 3. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14 updated October 2016, Chapter 2 revealed "The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment."	F 275	An audit of comprehensive assessments has been completed and significant change of condition has been initiated for those residents who did not have a comprehensive assessment completed in the last 12 months. 3. Address what measures will be put in place to ensure deficient practice will not recur. The Administrator (NHA), Director of Nursing Services (DNS), social service director, activity director (SSD), Minimum Data Set (MDS) coordinator and dietary manager have been educated on the RAI process. 4. How will the plan be monitored to ensure the solutions are sustained? In daily clinical meeting the Administrator will audit for validation using the Point Click Care (PCC) calendar that comprehensive Minimum Data Sets (MDSs) are completed according to the RAI process. This will become part of the daily clinical meeting. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The administrator is responsible for compliance. Compliance date: June 12, 2017	6/12/17
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	F 276		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 276	Continued From page 15 (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the MDS 3.0 RAI Manual, the facility failed to ensure a quarterly review was completed for 5 of 11 sample residents (#8, #12, #23, #38, #45) at least once every 3 months. The findings were: 1. Review of the medical record for resident #38 showed a significant change MDS assessment with an ARD of 12/1/16. The following concerns were identified: a. Review of the 12/1/16 significant change MDS assessment showed the assessment was not completed until 2/8/17, 69 days after the ARD. b. There was no evidence a quarterly MDS assessment was completed in the required 92 days from the last assessment date of 12/1/16. 2. Review of the medical record for resident #45 showed an annual MDS assessment with an ARD of 12/5/16. The following concerns were identified: a. Review of the 12/5/16 annual MDS assessment showed the assessment was not completed until 2/8/17, 65 days after the ARD. b. There was no evidence a quarterly assessment was completed in the required 92 days from the last ARD of 12/5/16. 3. Review of the medical record for resident #23 showed a quarterly MDS assessment with an	F 276	1. How corrective action accomplished for the identified residents? Quarterly Assessmants have been completed for residents #8,12,23,38 and 45. Resident #23 has had a significant change of condition to initiate the RAI process. 2. How you will identify other residents with the potential of being affected by the same practice? Audit of the quarterly assessments has been conducted and a significant change of condition has been initiated for those residents who have not had quarterly completed according to the RAI process. 3. Address what measures will be put in place to ensure deficient practice will not recur. The Administrator, MDS coordinator, SS director, activity director and dietary director have been educated on the RAI process 4. How will the plan be monitored to ensure the solutions are sustained.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 276	Continued From page 16 ARD of 12/5/16. The following concerns were identified: a. There was no evidence a quarterly assessment was completed in the required 92 days from the last ARD of 12/5/16. 4. Review of the medical record for resident # 8 showed a quarterly MDS assessment with an ARD of 11/1/16. The following concerns were identified: a. There was no evidence a quarterly assessment was completed in the required 92 days from the last ARD of 11/1/16. 5. Review of the medical record for resident #12 showed a quarterly MDS assessment with an ARD of 10/16/16. The following concerns were identified: a. There was no evidence a quarterly assessment was completed in the required 92 days from the last ARD of 10/16/16. 6. Interview with MDS coordinator #1 and MDS coordinator #2 on 5/10/17 at 4:36 PM confirmed the MDS assessments had not been completed in a timely manner. Further, the interview revealed the facility failed to employ adequate staff which resulted in the delay in MDS assessment completion. 7. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14 updated October 2016, Chapter 2 revealed "The ARD [assessment reference date] of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment	F 276	In daily clinical meeting the Administrator will audit for validation using the Point Click Care (PCC) calendar that comprehensive Minimum Data Sets (MDSs) are completed according to the RAI process. This will become part of the daily clinical meeting. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The administrator is responsible for compliance. Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 276	Continued From page 17 - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).".	F 276		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280	1. How corrective action accomplished for the identified residents? #11 has had a care conference to validate they have been involved in their care planning. 2. How you will identify other residents with the potential of being affected by the same practice? Care conferences have been scheduled for those resident who have not had a care planning meeting in the last quarter 3. Address what measures will be put in place to ensure deficient practice will not recur. The Administrator, Social Service director and DNS have been educated that care conferences are to offered quarterly in conjunction with the RAI process to validate resident and responsible party are involved in the care planning process.	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

st 6/12/17

(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 280	Continued From page 18 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280	Social Service Director will develop a calendar to notify staff and residents of when and what time there care conference is scheduled. 4. How will the plan be monitored to ensure the solutions are sustained? The Administrator will audit charts to validate there is documentation that the care conference had been completed. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The Administrator is responsible for compliance. Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 280	Continued From page 19 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to schedule care plan meetings with residents and resident families, to allow participation in their plan of care for a census of 46 residents. The findings were: 1. Interview with resident #11 on 5/8/17 at 5 PM revealed the resident had not been invited to or attended any meetings to discuss his/her care "for a while". 2. Group interview on 5/9/17 at 11 AM revealed 10 of 11 residents could not recall participating in care conferences. 3. Interview on 5/10/17 at 4:42 PM with MDS coordinator #1 confirmed care plan meetings had not been scheduled "for about six months."	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	1. How corrective action accomplished for the identified residents? Resident #45 has had their care plan updated to reflect their incontinent needs.	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 282	Continued From page 20 Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure services were provided as outlined in the care plan for 1 of 4 sample residents (#45) concerning incontinence. The findings were: 1. Review of the 12/5/16 annual MDS assessment showed resident #45 had diagnoses which included Huntington's disease, depression, insomnia, and somnolence. Further, the resident required extensive assistance of 1 person for bed mobility and total assistance of 1 person for toilet use and personal hygiene. Review of the "ADL Decline" careplan last reviewed 9/5/16 showed "provide assist for toilet use." Review of the "at risk for altered skin integrity/breakdown/pressure ulcers" care plan last revised 9/5/16 showed "check and change on rounds at NOC [night] and PRN [as needed]," "check and change upon rising/before & [and]/ or after meals at HS [hours of sleep] and PRN during the day," and "encourage and assist with frequent position changes." The following concerns were identified: a. Observation on 5/9/17 beginning at 8:08 AM showed the resident was laying in bed. CNA #4 and CNA #5 entered the room at 11:45 AM to assist the resident up and provide incontinence care, 3 hours and 37 minutes after the observation began. Further, the resident's mattress and linen were saturated with urine. b. Interview with the RDCO and MDS coordinator #2 on 5/10/17 at 4:56 PM revealed the resident should not have gone more than 2 hours without care being provided. 2. Review of the policy and procedure titled "Mosby's Textbook of Nursing Assistants" provided by the facility on 5/11/17 showed on	F 282	2. How you will identify other residents with the potential of being affected by the same practice? Resident care plans have been audited with the RAI process to validate their needs are addressed. 3. Address what measures will be put in place to ensure deficient practice will not recur. MDS, DNS and Administrator had been educated on checking care plans in the daily clinical meeting to validate changes have been made according to the resident needs. Nursing staff has been educated on following care plans; changing schedules, turning/repositioning, toileting etc. 4. How will the plan be monitored to ensure the solutions are sustained? The DNS / designee will conduct weekly random audits x 1 month then biweekly x 2 months to validate care plans have been updated to reflect resident needs. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. Facility will conduct random competency audits on 1 randomly chosen nursing staf member weekly x 90 days.	sk

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 282	Continued From page 21 page 386 "...Managing incontinence...Older Persons...Prevent episodes of incontinence during sleep. Limit the type of fluids in the evening. Follow the care plan..."	F 282	5. The DNS is responsible for compliance. Compliance date: June 12, 2017	6/12/17
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309	1. How corrective action accomplished for the identified residents? Residents # 23 and 38 have had no ill effects from nueros not being conducted after unwitnessed falls. 2. How you will identify other residents with the potential of being affected by the same practice? Any resident who had an unwitnessed fall have had the event audited to validate nueros were complete. 3. Address what measures will be put in place to ensure deficient practice will not recur. Licensed staff have been educated to complete nueros on all unwitnessed falls. 4. How will the plan be monitored to ensure the solutions are sustained?	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 309	Continued From page 22 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure an appropriate post fall assessment was completed for 2 of 3 sample residents (#23, #38) who had unwitnessed falls. The findings were: 1. Review of a significant change MDS assessment dated 12/1/17 showed resident #38 had diagnoses which included non-Alzheimer's dementia, heart failure, and hypertension. Further, the resident had a brief interview for mental status (BIMS) score of 5 (severely impaired) and had 1 fall since the prior assessment. The following concerns were identified: a. Review of a facility incident report dated 2/17/17 and timed 11:30 AM showed the resident was found sitting on the floor in front of his/her toilet. Further, the assessment was not marked under the "neuro checks [assessment] initiated" section. Review of the medical record showed no evidence neurological assessments had been completed. b. Review of a facility incident report dated 2/28/17 and timed 3:15 PM showed the resident was found on the floor after attempting to self-transfer from the bedside commode to the wheelchair. Further, the the incident report was marked "unnecessary" under the "neuro checks initiated" section. Review of the medical record showed no evidence neurological assessments had been completed.	F 309	During the daily clinical meeting the DNS designee will validate that nueros have been initiated and completed on unwitnessed falls 5 days per week. The Interdisciplinary Team (IDT) will cover the events of Friday, Saturday and Sunday during the Monday morning clinical meeting. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The DNS is responsible for compliance. Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 309	Continued From page 23 2. Review of the "fall scene investigation report" dated 3/5/17 showed resident #23 had an unwitnessed fall which resulted in a skin tear. The following concerns were identified: a. Review of the "checklist for fall incident report completion" showed it was marked as "NA" under "nueros initiated." There was no evidence to show neurological assessments were initiated after the unwitnessed fall. b. Review of the "investigators interview statement of event" record dated 4/30/17 showed the resident had a fall on that date. The record showed, "GNA walked into TV room to find res [resident] laying on the floor in front of his wc [wheelchair] - res in prone position." The fall was unwitnessed and resulted in a skin tear. Further, there was no evidence to show neurological assessments were initiated. 3. Review of the Fall Evaluation and Management policy, last update 4/2017 showed "... The LN [licensed nurse] evaluates neuro checks for 24 hours for all falls unwitnessed by staff, or falls that involve the resident's head striking a surface..." 4. Interview with the RCDO and MDS coordinator #2 on 5/10/17 at 5:05 PM revealed all unwitnessed falls should have neurological assessments completed.	F 309		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used– (1) In excessive dose (including duplicate drug	F 329	1. How corrective action accomplished for the identified residents?	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that– (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medications were appropriate for 8 of 12 sample residents (#8, #11, #12, #23, #36, #38, #42, #45). The findings were:	F 329	Residents # 8,11,12,23,36,38,42and 45 have had a IDT behavior med review meeting to validate the medication continues to be appropriate, behavior monitoring sheet have been put in place, consents in place and Gradual Dose Reduction (GDR) initiated as warranted. 2. How you will identify other residents with the potential of being affected by the same practice? An audit of residents on psychotropic medications has been completed and IDT behavior meeting has been conducted including initiating behavior monitoring sheets and GDR request if warranted. 3. Address what measures will be put in place to ensure deficient practice will not recur. Social Service Director has been educated on Empres Policy and Procedure for psychotropic medication. Staff have been educated to report behaviors to their nursing supervisor so that they can document behaviors. Licensed nurse have been educated on appropriate documentation of behaviors.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 1. Review of the 11/1/16 quarterly MDS assessment showed resident #8 had diagnoses which included depression. Review of the physician orders showed the resident received sertraline (an antidepressant) 50 mg by mouth every day. The following concerns were identified: a. Review of the medical record showed the facility had not implemented a system for monitoring and evaluating the effectiveness of the medication. 2. Review of the 4/26/17 annual MDS assessment showed resident #12 had diagnoses which included depression. Review of the physician orders showed the resident received citalopram (an antidepressant) 10 mg by mouth every day. The following concerns were identified: a. Review of the medical record showed the facility had not implemented a system for monitoring and evaluating the effectiveness of the medication. 3. Review of the 1/9/17 quarterly MDS assessment showed resident #11 had diagnoses which included depression. Review the physician's orders showed the resident received escitolopram (an antidepressant) 10 mg by mouth every day. The following concerns were identified: a. Review of the medical record showed the facility had not implemented a system for monitoring and evaluating the effectiveness of the medication. 4. Review of physician's orders for May 2017 showed resident #23 was prescribed quetiapine fumarate (an antipsychotic) 50 mg daily at night, mirtazipine (an antidepressant) 15 mg daily at night, and temazepam (a sedative) 15 mg as needed at night for insomnia. Further review	F 329	4. How will the plan be monitored to ensure the solutions are sustained? The DNS/ Designee will conduct weekly random audits to validate behaviors are being monitored. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The Administrator is responsible for compliance. Compliance date: June 12, 2017	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

ak 6/12/17

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26 showed the quetiapine fumarate and been increased from 25 mg to 50 mg on 3/23/17. There was no evidence the facility had implemented a system for monitoring and evaluating the effectiveness of these psychotropic medications. 5. Review of the 12/1/16 significant change assessment showed resident #38 had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder. Review of the physician's orders showed the resident received Ativan (an antianxiety) 0.25 mg by mouth three times per day. The following concerns were identified: a. Review of the medical record showed the facility had not identified specific behaviors related to the medication use. Further, there was no evidence the facility was monitoring behaviors to identify or track the medication effectiveness. 6. Review of the 12/5/16 annual MDS assessment showed resident #45 had diagnoses which included Huntington's disease, depression, insomnia, somnolence, and psychosocial circumstances. Review of the physician orders showed the resident received clonazepam (an antianxiety) 0.75 mg by mouth every day, fluoxetine (an antianxiety) 20 mg by mouth every day, and haloperidol (an antipsychotic) 1 mg by mouth twice per day. The following concerns were identified: a. Review of the medical record showed the facility had not identified specific behaviors related to the medication use. Further, there was no evidence the facility was monitoring behaviors to identify or track the medication effectiveness. 7. Interview with RDCO and MDS coordinator #2	F 329		

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 on 5/10/17 at 5:05 PM revealed a system for monitoring and evaluating the effectiveness of medications existed, but had not been implemented at that time.	F 329		6/12/17
F 371 SS=E	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure equipment was in good repair in 1 of 1 food preparation area (kitchen). The findings were:	F 371	1. How corrective action accomplished for the identified residents? No residents were identified 2.How you will identify other residents with the potential of being affected by the same practice? All residents have the potential to be affected. Dietary manager has audited all the water carafes and pitchers and disposed of those with cracks or fissures in them and replace with new ones. 3. Address what measures will be put in place to ensure deficient practice will not recur. Dietary staff have been educated to discard any kitchen items with cracks or fissures and to report to the dietary manager.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 371	Continued From page 28 1. Observation on 5/10/17 at 10:20 AM showed a 60 oz pitcher, two 32 oz pitchers, and 10 of 12 water carafes in use had cracks and fissures which could not be effectively cleaned. 2. Interview with the dietary manager on 5/10/17 at 12:12 PM confirmed the items needed to be replaced because they could not be effectively cleaned. 3. According to Food Code 2013, U.S. Public Health Service 4-101.11 " Materials that are used in construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not be allowed the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. "	F 371	4. How will the plan be monitored to ensure the solutions are sustained? Dietary manager will complete monthly audits of water carafes and pitchers to validate there are no cracks or fissures in them. Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The Dietary Manager is responsible for compliance. Compliance date: June 12, 2017	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431	1. How corrective action accomplished for the identified residents? No residents were identified.	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 431	Continued From page 29 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	2. How you will identify other residents with the potential of being affected by the same practice? All residents have the potential to be affected. Audit was conducted of the medication storage unit and any meds that are expired have been discarded. All expired Meds found during initial audit were disposed of. 3. Address what measures will be put in place to ensure deficient practice will not recur. A schedule has been completed to check for expired meds weekly and discard of. Licensed staff has been educated on looking at expiration dates and discarding of expired meds appropriately. 4. How will the plan be monitored to ensure the solutions are sustained? The DNS will conduct random weekly audits x 1 month them monthly x 3 to validate there are no expired medications	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 431	Continued From page 30 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure medications were not expired in 1 of 3 medication storage areas, (the storage closet). The findings were: 1. Observation of the medication storage closet located near the nurses' station on 5/10/17 at 3:45 PM revealed the following: a. Two 1000 ml (milliliter) bags of lactated ringers intravenous solution had an expiration date of 1/17. b. Four 1000 ml bags of 0.45 normal saline intravenous solution had an expiration date of 5/16. 2. Interview with LPN #2 on 5/10/17 at 3:45 PM revealed the medications in the medication storage closet were available for resident use and were past their expiration date.	F 431	Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The DNS is responsible for compliance Compliance date: June 12, 2017	
F 501 SS=E	483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR (h) Medical director. (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.	F 501	1. The facility has obtained a fully executed Medical Director contract. 2. All residents are affected.	6/12/17

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD 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 501	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure a medical director was designated for the facility. The census was 46. The findings were: Interview with the administrator on 5/11/17 at 8:54 AM revealed the facility did not have a medical director since the facility's change of ownership in February 2017. Further, it was revealed the new contract would not be active until June 2017 and the facility had not received any services from the medical director.	F 501	3. The RVOP will educate ED on the definition, tasks and functions of a medical director. ED/designee will validate that the facility has an active Medical Director contract in effect at all times. 4. The facility will audit weekly X 90 days Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The ED is responsible for compliance. Compliance date: June 12, 2017	6/12/17
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality	F 520	1. The facility will maintain a quality assessment and assurance committee. 2. All residents are affected. 3. a. The committee will consist of at a minimum the DNS, Medical Director and at least 3 members of the facility's staff, at least one of who must be the administrator, owner, board member or other individual in a leadership role.	

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/11/2017

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

sk 6/12/17

(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 520	Continued From page 32 assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify 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 quality assessment and assurance (QAA) meeting minutes, and staff interview. The facility failed to ensure a QAA program was implemented. The census was 46. The findings were: Review of the QAA minutes showed the last QAA meeting was held on 4/7/17. The most recent meeting prior to 4/7/17 was held in September of 2016. Interview with the administrator on 5/11/17 at 8:54 AM revealed the QAA program was placed on hold due to a lack of appropriate staff to participate in the committee. He confirmed the committee met in April 2017; however, it was revealed the program was still not fully implemented at that time.	F 520	b. The committee will meet at least quarterly to develop and implement appropriate plans of action, c. Administrative staff to be in-serviced on the requirement and significance of a QAA Committee. 4. The facility will audit weekly X 90 days Findings of audits to be brought to QAPI for evaluation and further educational opportunities. 5. The ED is responsible for compliance. Compliance date: June 12, 2017	