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 01/04/2018

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 complaint survey was conducted by Healthcare Licensing and Surveys from 1/2/18 to 1/4/18. The survey was prompted by complaint intakes WY000002523 and WY000002542. The following common abbreviations are used throughout this document: ADLs: Activities of daily living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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, and medical record review, the facility failed to ensure residents received necessary assistance for 1 of 3 sample residents (#4) requiring assistance with ADLs. The findings were: Review of the 12/1/17 significant change MDS assessment showed resident #4 had diagnoses that included Alzheimer's disease. Further review showed the resident required extensive assistance of 1 staff person for personal hygiene. Review of the care plan for ADLs, revised	F 677	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Thermopolis Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements,	2/8/18

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

Electronically Signed | 01/29/2018

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 01/04/2018

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 677	Continued From page 1 10/27/17, showed the resident required "assistance of one staff with personal hygiene and oral care." Further review showed the resident's "oral care routine" was in the morning, after meals, and at bedtime. Observation on 1/3/18 at 8:13 PM showed CNA #1 offered to assist the resident to bed. The CNA assisted the resident with toileting, then into bed. The CNA did not provide or offer to provide oral care to the resident at that time. Interview with the administrator, LPN #1, and the regional clinical director on 1/4/18 at 12:02 PM confirmed the CNA should have attempted to assist the resident with oral care.	F 677	facts, and conclusions that form the basis for the deficiency. F 677 1. Resident #4 was offered oral care upon identified concern on 1/4/18. CNA #1 was provided education regarding when to offer oral care for residents on 1/10/18, 1/17/18 and on 1/23/18. 2. All residents are identified to have the expectation of offering/providing oral care as part of their plan of care. Oral care audits performed from 1/8 to 1/10/18 on resident population to ensure oral care is being offered/provided and care plans were adjusted accordingly. 3. Education was provided by the DNS/Designee on 1/10/18 to licensed nursing staff regarding offering and providing oral cares for residents per their care plan. In addition further extensive oral hygiene training was presented by the community dentistry clinic to licensed nursing staff on 1/17/18. 4. Audits will be conducted at random on all shifts weekly by the DNS or designee on observance of offering/providing oral cares for residents X 4 weeks, then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI x 3	

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 01/04/2018

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 677	Continued From page 2	F 677	months or until resolved. Date of Compliance: 2/8/18	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of activities calendars, the facility failed to provide meaningful facility-sponsored activities in 1 of 2 resident units (secure unit). The findings were: 1. Review of the January activities calendar showed scheduled activities for 1/2/18 included "Afternoon Movie" at 2:30 PM. No activities were scheduled for the rest of the afternoon or evening. Observation on 1/2/18 from 2:25 PM to 3:12 PM showed 4 residents were sitting in the television area, with the television tuned to a TV rerun. Further observation showed 3 additional residents sitting or wandering in the hall. There was no evidence the scheduled activity was offered. 2. Review of the January activities calendar showed the scheduled activities for 1/3/18 were	F 679	F679 1. The Activities Director and assistants were immediately educated on 1/10/18 and again on 1/25/18 by the ED regarding providing a structured activity program with meaningful activities provided in the evening as well. The activities calendar was immediately re-evaluated with focus on the residents in the secured unit by the Activities Director and her team on 1/17/18. 2. All residents residing on the unit are identified to be at risk of activities meeting their specified need/interest. Resident population surveyed to define and determine activity preferences.	2/8/18

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 01/04/2018

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 679	Continued From page 3 "Fun with Food" at 9:30 AM, "Table Time" at 9:45 AM, "Massage/Relax" at 1 PM, "Hand Therapy" at 1:30 PM, and "Coloring" at 2 PM. No activities were scheduled for the rest of the afternoon or evening. Observation on 1/3/18 at 9:50 AM, 10 AM, 10:45 AM, and 1:30 PM in the secure unit showed the scheduled activities or other structured activities were not being provided. Residents were sitting or wandering in the hall and dining room, in their rooms, or in the television area with the TV turned on. The radio in the dining area of the unit was playing, with the volume turned low. 3. Interview with LPN #2 on 1/3/18 at 1:45 PM revealed activities did not get done in the unit and "there is no program back here." She stated she felt there was minimal resident engagement. She revealed the radio playing in the dining room was considered the current activity. She further stated activities were documented as being completed, but were not actually offered. 4. Interview with activities assistant #1 on 1/3/18 at 1:48 PM revealed she had not offered any activities in the secure unit that day because she was trying to "catch up on paperwork." She further stated on the previous day, the only activity that was offered was cards, but the resident with whom she tried to play had poor attention to the game and the activity lasted just a few seconds. She added the only activity residents usually participated in was watching television. 5. Interview on 1/4/18 at 8:40 AM with the activities director revealed she evaluated the activities program in the unit by making observations of the activities in progress. She	F 679	3. Education was provided by the ED/designee to the Activities Director on 1/25/18 regarding the expectation of providing activities that meets the interests of the residents as scheduled with particular focus on restructuring type and frequency of activities offered on the secured unit. Furthermore the Activity Director researched new recommended options for activities on the secured unit to meet their interest needs, this has been put into place with a new activities calendar issued to the residents reflecting the changes including offering of evening activities. Also, Activity Aide schedule being changed to accommodate evening activities in the Memory Care Unit. 4. Audits will be conducted by the Activities Director/designee at random times (including evening) of scheduled activities to ensure the activity is being offered, and residents are offered to participate. Audits to be conducted weekly X 4 weeks, then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI x 3 months or until resolved. Date of Compliance: 2/8/18	

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 01/04/2018

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 679	Continued From page 4 stated when she observed in the secure unit the activities assistant would usually be doing "table time" activities. She further stated the residents in the secure unit had decreased attention and often wandered in and out of activities. She further confirmed there were no activities scheduled after 4 PM in the secure unit because the residents went right to bed after dinner.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review the facility failed to implement interventions to prevent a recurring pressure ulcer for 1 of 3 sample residents (#30) with pressure ulcers. The findings were: 1. Review of the quarterly MDS assessment dated 11/23/17 showed resident #30 had diagnoses which included multiple sclerosis. Further review showed the resident required total assistance with cares, was incontinent, and was	F 686	F 686 1. Resident # 30 resides at the Center at this time and has since healed the pressure ulcer on 1/18/18. An air mattress was placed immediately on 1/5/18 as well as their care plan updated to reflect the air mattress and the residents frequent noncompliance with repositioning as a risk for skin breakdown.	2/8/18

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 01/04/2018

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 686	Continued From page 5 at high risk for pressure ulcers. Observation on 1/2/18 at 4:55 PM showed the resident lying on his/her back in bed, on a standard facility mattress. The following concerns were identified: a. Review of the Weekly Skin Evaluation dated 11/27/17 showed "old area of breakdown to coccyx has reopened" and had the following measurements: length 0.75 cm, width 0.25 cm, depth 0.1 cm. b. Review of the Weekly Skin Report; Pressure Ulcers, dated 12/28/17, showed the pressure ulcer worsened and had the documented measurements: length 1 cm, depth 0.25 cm. c. Interview with LPN #1 on 1/3/18 at 11:20 AM confirmed the resident had a previous pressure ulcer to the coccyx area, and added that an air mattress was placed on the resident's bed. She stated once the pressure ulcer healed, the air mattress was removed. She further stated the resident did not like to be repositioned in bed and when staff attempted to reposition the resident, s/he would roll back to the original position. d. Interview on 1/3/18 at 3:45 PM with LPN #2 revealed staff had been applying lotion to the affected area and repositioning the resident every 2 hours, but the resident would return to his/her preferred position of lying on his/her back. The LPN also revealed the facility had only one air mattress and it was being used for another resident e. Interview with the interim DON on 1/2/18 at 4:20 PM revealed she was hired into her position the previous week. She stated she recognized when she started that the skin and wound documentation was poor, so she and another nurse did a skin assessment of all of the residents at the facility to update the documentation, obtain orders, and initiate	F 686	2. All residents with a current pressure ulcer or have a history of a pressure ulcer are determined to be at risk. An audit was conducted by the DNS/designee on 1/11/18 for review of all residents determined to be at risk and appropriate interventions in place to facilitate optimal healing/reduce risk of developing a pressure ulcer. 3. Education was provided by the DNS/Designee to Licensed Nurses on skin integrity interventions including the use of an air mattress if appropriate, prevention of skin breakdown, and documentation of pressure ulcer prevention interventions on 1/10/18 and 1/25/18. 4. Audits will be conducted by the DNS/Designee on all residents with pressure ulcers or have a history of for appropriate interventions in place and documentation accordingly weekly X 4 weeks then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI X 3 months or until resolved. Date of Compliance: 2/8/18	

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 01/04/2018

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 686	Continued From page 6 treatment if warranted.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure resident safety with transfers during 1 random observation (resident #24). The findings were: Review of the 12/19/17 significant change MDS assessment showed resident #24 had diagnoses that included hip fracture, Alzheimer's disease, and psychotic disorder. Further review showed the resident required extensive assistance of 1 person for transfers. The following concerns were identified: a. Observation on 1/3/18 at 10:47 AM showed CNA #2 approaching the resident's room to get him/her up from bed. Interview with CNA#2 at that time revealed the resident's transfer status varied, but s/he was usually able to stand and pivot with a staff member assisting. If the resident was unable to stand, then staff used a mechanical lift. b. Observation on 1/3/18 at 10:57 AM showed CNA #2 and shower aide #1 transferred the resident from the bed to a shower chair. The resident sat on the edge of the bed with both legs	F 689	F 689 1. Resident #24 was reevaluated by the IDT to determine the safest transfer status of utilizing a mechanical lift for all transfers and their care plan was updated accordingly. Shower aide #1 received transfer training and education by the DNS/Designee regarding safe transfers on 1/10/18 and again 1/25/18. CNA #2 is a seasonal employee and has been subsequently terminated as she returned to college. 2. All residents residing in the facility have been identified to be at risk. Audits performed to ensure accurate transfer status of all residents and care plans reviewed/adjusted accordingly. 3. Education was provided by the DNS/designee to Licensed Nursing staff on 1/10/18 and on 1/25/18 regarding transfer training, safe transfers including	2/8/18

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 01/04/2018

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 689	Continued From page 7 drawn up toward the chest. The CNA and the shower aide placed their arms under each of the resident's arms and lifted the resident from the bed to the shower chair. The resident's legs remained drawn up toward the chest, and did not touch the floor during the transfer. c. Interview with LPN #2 on 1/3/18 at 3:05 PM confirmed the resident usually was able stand and pivot for transfers, but they sometimes used a mechanical lift. She revealed if the resident was unable or unwilling to bear weight during a transfer, the expectation was to use a mechanical lift.	F 689	utilizing a mechanical lift for transfers, and care planned documentation for transfer status. Therapy has been scheduled to provide in-service for all clinical staff regarding transfer safety and body mechanics on Tuesday, 2/13/18 by a representative from therapy contractor.. 4. Observational Audits will be conducted weekly by the DNS/designee at random of resident transfers to ensure transfer is done according to care plan and performed safely weekly X 4 weeks, then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI x 3 months or until resolved. Date of Compliance: 2/8/18	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		2/8/18

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 01/04/2018

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 725	Continued From page 8 at §483.70(e). §483.35(a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) 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 resident and staff interview, review of daily staffing schedules, and review of the "Facility Assessment Tool," the facility failed to ensure adequate nurse aide staffing. The census was 43. The findings were: Review of the 10/31/17 "Facility Assessment Tool" showed: "For CNAs we prefer to have 2 on the main floor and 1 in the Memory Care Unit 24/7." The following concerns were identified: a. Interview on 1/2/18 at 2:50 PM with CNA #3 revealed she had worked 102 hours in the last pay period. She stated she typically worked 9 AM to 9 PM and helped residents lie down at night. She further revealed there was frequently only one CNA at night on the main floor. b. Interview on 1/2/18 at 3:15 PM with shower aide #2 revealed she often was removed from her shower duties to work as a CNA. She further stated most weeks residents only received one bath a week. She also stated she worked 10-12	F 725	F 725 1. The staffing matrix was reviewed upon finding on 1/4/18, The current schedule was then modified to allow for a 1 nurse and 3 CNA ratio effective 1/4/18. 2. All residents currently residing in the facility are identified to be at risk. 3. Education was provided by the ED/Designee to the DNS and nursing IDT regarding preferred staffing ratios at night per the center assessment on 1/10/18 and on 1/25/18. Additional systemic changes to accomplish this includes heavy recruitment of CNA□s using local area papers, Newton (Indeed), Craigslist and focus on retention/collaborative team approach (using ABC Employee of the Month). Facility to implement Weekend	

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 01/04/2018

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 725	Continued From page 9 hour shifts five days a week. c. Interview with resident #13 on 1/2/18 at 2:44 PM revealed facility staffing was poor and most nights there was only one nurse aide on the floor. The resident also stated sometimes s/he had to wait up to 45 minutes to go to the bathroom. d. Interview on 1/2/18 at 3:45 PM with resident #10 revealed s/he often waited 1 1/2 hours to go to bed. Additionally, the resident stated s/he had waited 2 hours for assistance while on the toilet. e. Interview on 1/2/18 at 4:20 PM with the interim DON revealed she was hired into her position the previous week. She stated the facility's staffing levels were "not good" when she started. She confirmed that filling the schedule for the month of January was difficult, and schedules for previous months had been put out with unfilled spots. She stated previous schedules showed only one CNA scheduled to care for 30 residents and "you can't take care of 30 people with 1 CNA." f. Interview with 12 residents on 1/3/18 at 11:10 AM revealed they had concerns with staffing at the facility. Six residents expressed frustration with not getting showers as often as they wished because the shower aide had to work as a CNA due to staff shortages. One resident stated, "Sometimes sponge baths don't cut it. It's nothing any of us has done." The residents agreed they frequently had to wait 30-45 minutes for staff to answer call lights and provide assistance. Three residents revealed there had been times when they had to wait so long to get assistance to the toilet they were unable to wait any longer and soiled themselves. g. Interview with LPN #2 on 1/3/18 at 1:56 PM revealed the facility was short-staffed. She stated	F 725	Nurse Manager on- call to deal with call-offs and fill the open position in the case that coverage cannot be found in times of staffing challenges. 4. The ED/designee will conduct audits on staffing ratios daily with emphasis on the night shift for appropriate ratios weekly X 4 weeks then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18 . Results of the Audits will be taken to QAPI x 3 months or until resolved. Date of Compliance: 2/8/18	

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 01/04/2018

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 725	Continued From page 10 it was difficult for 1 CNA to take care of all the residents on the main floor. h. Interview with the administrator on 1/3/18 at 2:40 PM revealed there was no specific formula used to determine staffing needs, but the ideal staffing would be 1 nurse and 3 CNAs on the night shift. He acknowledged there were numerous nights where the staff consisted of 1 nurse and 2 CNAs from 10 PM to 5:00 AM. He stated an extra CNA worked until 10:00 to help assist residents to bed, and during the night the staff helped each other to cover both the main floor and secure unit. He further revealed the facility currently had 3 openings for CNAs, and corporate policy was to not hire traveler CNAs. i. Review of the December 2017 employee staffing schedule and daily staff posting showed 15 night shifts were staffed with 1 nurse and 2 CNAs.	F 725		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).	F 728		2/8/18

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 01/04/2018

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 728	Continued From page 11 §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and employee record review, the facility failed to ensure individuals functioning as a nurse aide during 1 random observation (activities assistant #1) were qualified and competent. The findings were: Interview with activities assistant #1 on 1/2/18 at 3:22 PM revealed she was an activities assistant and an environment nursing assistant (EA). Observation on 1/3/18 at 10:47 AM showed CNA #2 approached activities assistant/EA #1 to request assistance with getting up resident #24 from bed. The CNA removed the resident's dirty brief, then began to clean the resident. The activities assistant/EA assisted the CNA with	F 728	F 728 1. The activities assistant #1 received education immediately regarding her scope of duties/practice as an EA by the Divisional Director of Clinical Operations on 1/4/18, she verbalized understanding of not performing personal cares or functioning in a CNA type role. The ED also personally in-serviced staff member on 1/8/18. 2. Any EA staff member is identified to be at risk of the above if not provided the appropriate education and guidance. 3. The DNS/designee provided	

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 01/04/2018

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 728	Continued From page 12 holding the resident's legs during perineal care, then with repositioning the resident while the CNA placed a clean brief. Review of the employee file for activities assistant/EA #1 showed she was hired as an activities assistant. There was no evidence she was qualified and competent to assist with performing resident cares. Review of the EA job description showed an EA's functions included answering call lights, making beds, serving meals or fluids, transporting residents, and other non-personal care tasks. Interview with the administrator on 1/4/18 at 10:20 AM confirmed the activities assistant was also an EA. He stated she completed a CNA class but did not pass the test. Additionally, he stated the expectation was for EAs to provide non-personal care only.	F 728	education to all EA staff members of the facility on 1/10/18 and 1/25/18 regarding their scope of practice and to never perform personal cares for residents that are duties otherwise only approved for CNA□s. Additional systemic changes include providing this education as part of the orientation process for any new hired EA□s in the future. 4. The DNS/designee will conduct random observational audits of EA□s to ensure nothing is being performed outside of their assigned duties, weekly X 4 weeks, then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI x 3 months or until resolved. Date of Compliance: 2/8/18	
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		2/8/18

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 01/04/2018

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 732	Continued From page 13 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of the daily staff roster, and staff interview, the facility failed to ensure the posted 24 hour nursing staff information was maintained and updated to reflect the actual staff hours worked, and facility census for 16 of 16 days reviewed. The findings were: Observation of posted staffing on 1/2/18 at 2:15 PM showed it failed to include the facility census and actual staff hours worked.	F 732	F 732 1. The 24 hour nursing staff information posting was immediately corrected upon finding to reflect the actual staff hours worked, and facility census on 1/4/18. 2. There are no additional postings found insufficient at this time in the facility.	

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 01/04/2018

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 732	Continued From page 14 Review of the daily rosters from 12/20/17 through 1/4/18 showed actual staff hours worked and facility census were not included. Interview with LPN #2 on 1/2/18 at 3:00 PM revealed she posted the daily roster and was told what information to include on the daily roster. She further stated she was unsure of the posting requirements.	F 732	3. The ED/Designee provided education to the facility Nursing leadership team regarding accuracy of the 24 hour nursing staff posting daily including accurate census on 1/10/18 and on 1/25/18. 4. The ED/Designee will conduct daily audits on the 24 hour nursing staff posting for accuracy of staff hours worked and accurate census weekly X4 weeks, then monthly X 2 months. Results of the initial corrections, audits and education were submitted in an AdHoc QAPI meeting on 1/29/18 for review and recommendations. The plan of correction was accepted by the QAPI committee on 1/29/18. Results of the Audits will be taken to QAPI x 3 months or until resolved. Date of Compliance: 2/8/18	