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

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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
	535061	A. BUILDING _____ B. WING _____	C 11/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD 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 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of personnel files, the facility failed to implement established policies for performing background checks on one of six sample employees prior to hiring. The findings were: Six personnel records selected from among employees with less than 120 days of employment at the facility were reviewed on 11/18/08 at 2:10 PM. One employee, registered nurse (RN) #3, had a hire date recorded as 9/26/08. However, the only documentation in the record for preemployment screening was dated 11/18/08, the same day selected records was requested for review. The business office manager (BOM) stated in an interview on 11/18/08 at 2:40 PM the facility runs a background check for criminal records or issues related to abuse and neglect through an outside agency. The established policy requires the check to be completed and the employee to be without record of any incident prior to completing the hiring action. She confirmed the date of the background check as 11/18/08 and stated she was not aware of any other documentation obtained prior to hiring. The director of nursing (DON) stated in an interview on 11/18/08 at 3:15 PM she had received a background check on RN #3 prior to hiring her, but was unable to find the documentation. The missing documentation	F 226	F 226 483.13(c) The employee in question no longer works at this facility. A new procedure has been put in place to audit all personnel files prior to start date of employee. All department heads will be in serviced r/t new procedures. The BOM will audit all personnel files and the new employee will be assigned to duties only after the BOM has notified the department head that the employee is cleared for beginning work. Employee files will be audited monthly for QA for 3 months and quarterly thereafter of accuracy. Personnel files will be audited by the BOM.	1/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/15/08

...y 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. 12/22/08 POC amended and accepted per telephone call with administrator. ppmey, cw

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F 226	Continued From page 1 prompted the DON to request another check be completed on 11/18/08. The facility administrator was interviewed on 11/19/08 at 8:20 AM regarding the conflicting statements of the BOM and DON regarding whether a background check had been completed on RN #8 prior to hiring her. He stated he was unable to reconcile the discrepancy and confirmed the record appeared incomplete at the time the RN was hired.	F 226	F 241 483.15(a) 1. Nursing staff has been in serviced r/t incontinence care. Nursing staff has been instructed that residents will be toileted upon request and peri care will be offered to each resident. It is not the policy of this facility to tell residents that we can't toilet them until after the dining room is empty. Nursing staff was also educated r/t answering call lights promptly, cleaning wheelchairs when the resident has been incontinent and prn, knocking on doors and announcing self prior to entering a resident room. Resident #18 has been provided a one on one ambassador that meets with her daily. Any concerns or complaints are brought to the interdisciplinary committee for further action.	11/15/08
F 241 SS=G	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to preserve dignity and respect for two (#15, #18) of 12 sample residents. This lack of respect and dignity resulted in avoidable psychosocial harm expressed by feelings of humiliation for one (#18) resident. The findings were: 1. Review of the 9/16/08 Initial Minimum Data Set (MDS) assessment for resident #18 revealed s/he was usually continent. Review of the 9/15/08 quarterly MDS assessment revealed s/he was frequently incontinent but still retained some bladder control. Each of the MDS assessments revealed the resident required limited assistance of one for toileting and personal hygiene. The two MDS assessments revealed the resident was cognitive, independent in decision making skills, was understood, and able to understand. Review	F 241		11/15/08

pp

F241 Revision

483.15(a)

1/15/09

2. Resident #15 has been evaluated and does require assistance with personal hygiene and ADLS.Nursing staff will be educated related to not allowing residents to leave the dining room with food or drink on their clothing, hands and faces. Wipes will be placed in the dining room for this purpose. The Administrator, DON/designee will make random rounds of resident's appearance particularly after meals. The results of these rounds will be reported at monthly QA meetings for 3 months and quarterly thereafter.

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F 241	Continued From page 2 of the 9/22/08 care plan revealed the resident was usually continent of bladder. During an interview with the director of nursing (DON) on 11/19/08 at 10:10 AM, she stated the resident was usually continent of bladder. The following concerns were identified: a. Interview with the resident on 11/18/08 at 6:40 PM revealed s/he had asked a certified nurse aide (CNA) to assist him/her to the toilet for urination around 6:10 PM but was told by the CNA that the resident must wait until all other residents were assisted from the dining room. b. Observation on 11/18/08 at 6:50 PM revealed the resident turned on the call light and again requested assistance to use the toilet. At that time, forty minutes after the resident's request, CNA#1 assisted the resident to the toilet where observation revealed the resident's slacks, incontinence brief, and wheelchair cushion was saturated with urine. In addition, observation revealed a puddle of urine was on the floor where it had run off the wheelchair cushion. Interview with the CNA on 11/18/08 at 6:50 PM revealed she had to wait until all residents were out of the dining room before assisting the resident with other cares. Interview with the resident on 11/18/08 at 2:48 PM revealed s/he was humiliated about the incident. c. Interview with the DON on 11/19/08 at 10:10 AM revealed resident #18 took great pride and joy in his/her appearance. She further stated this incident must have been "very hard on the resident." In addition, review of the 9/29/08 care plan for this resident revealed s/he had a visual impairment and one of the interventions was to announce yourself when entering the room. However, observation on 11/18/08 at 7:12 PM revealed CNA #2 entered the room without	F 241	F 241 cont. The DON/designee will perform random audits regarding proper procedure before entering a resident room, toileting and incontinence care. The results of these audits will be presented monthly at QA meetings. Thereafter the audit results will presented quarterly at QA meetings.	1/15/08

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F 241	Continued From page 3 knocking or announcing herself. Interview with the resident on 11/18/08 at 2:48 PM revealed s/he did not like having staff enter the room without knocking or announcing themselves first. 2. Review of the 10/3/08 quarterly MDS assessment for resident #15 revealed the resident had moderate cognitive impairment and required extensive assistance with personal hygiene. Observation on 11/16/08 from 6:05 until 9:00 PM revealed the resident self propelled himself/herself throughout the halls of the facility with dried food caked on the corner of his/her mouth and food stains and crumbs on his/her clothing. Additional observation revealed at least six different staff members walked by the resident without providing the grooming and personal hygiene care the resident needed to enhance his/her dignity. Interview on 11/19/08 at 11:00 AM with licensed practical nurse (LPN) #1 confirmed the resident did not have the cognitive ability to provide grooming and personal hygiene care without staff assistance.	F 241	F 253 483.15(h) 1. Areas of cracked and/or separated flooring are being replaced. 2. Plastic handrails have been ordered to replace the wooden handrails. Wooden handrails have been painted with a sealer to facilitate washing and disinfection. 3. Plastic handrails have been ordered to replace and repair missing end caps and irregular surfaces at seams. 3. The areas of worn flooring in the dining room are being replaced. 5. The doors in resident room 4 have been repaired. We are in the process of purchasing and installing new protective panels to doors.	11/24/08
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain maintenance and housekeeping services to sustain sanitary and comfortable conditions in five of seven hallways. The findings were: Observations over four days of survey revealed	F 253		1/15/09

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F 253	Continued From page 4 areas within the interior of the facility in disrepair and with an unkept appearance. High trafficked areas in resident hallways A, B, C, E, F, the dining room, and the special care unit (SCU) showed the following problems: 1. The flooring was excessively worn and contained gouges, cuts, and separations in the linoleum. Areas of the flooring were cracked and showed separation where previous repairs had been attempted. 2. The finish on wooden handrails in resident hallways A and B was worn to bare wood and was no longer a cleanable surface. 3. Five portions of the handrails in the SCU lacked end caps or the existing end caps were cracked. Seven areas along this same hallway had irregular surfaces at the seams of adjacent handrail sections. 4. The linoleum flooring in the main dining room exhibited areas of excess wear, revealing cracks, mars, gouges, and separations at seams in the flooring material. 5. Pervasive throughout the facility were gouges and scratches in wooden doors. The doors were scratched through the finish coat and exposed bare wood; the most extreme example was seen in resident room number four where the wooden bathroom door had a hole through the bottom and a splintered surface. 6. An upholstered chair in the television lounge had a network of cracks through the plastic covering on the bottom cushion. The cracked areas were discolored and stained.	F 253	F 253 cont. 6. The upholstered chair in the television lounge has been removed from the building. The Administrator, DON, and Maintenance Supervisor will conduct random building rounds and present the results of those audits at the monthly QA meetings for 3 months. Further audits will be presented quarterly or on an as needed basis.	11/5/08

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F 253	Continued From page 5 The maintenance supervisor confirmed in an interview on 11/19/08 at 10:15 AM the worn and damaged flooring in the facility. He revealed the facility had plans for repairing and replacing the flooring, but was uncertain when the proposed repairs would be initiated. The housekeeping supervisor was present at the same time and confirmed the uncleanable surfaces on the worn handrails and flooring. Both staff members confirmed the damaged appearance of residents' doors.	F 253		1/15/09
F 258 SS=E	483.15(h)(7) ENVIRONMENT- SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of resident council minutes, the facility failed to ensure the facility was quiet at night on one of two nursing units. The findings were: Review of the resident council minutes for 10/7/08 and 11/4/08 revealed residents had verbalized concerns about staff being noisy at night. During a confidential resident meeting on 11/17/08 at 3 PM residents again stated staff were too noisy at night. They further stated one certified nurse aide (CNA) would yell down the hallway to another CNA which was disturbing for residents. Interview with the director of nursing on 11/19/08 at 10:10 AM revealed she was aware of the problem and had discussed it with staff at a recent staff meeting.	F 258	F 258 483.15(h)(7) All staff has been in serviced related to noise level at night. Staff has been instructed to talk in very soft voices, especially at night. DON/Designee will conduct random audits and present findings monthly for 3 months at QA meetings and quarterly on an as needed basis thereafter.	1/15/09
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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F 281 SS=D	Continued From page 6 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed physicians' orders for three (#7, #18, #39) of 12 sample residents and one (#49) non sample residents. The findings were: 1. Review of the 6/16/08 initial Minimum Data Set (MDS) assessment for resident #18 revealed s/he experienced moderate back and leg pain less than daily. Review of the 9/15/08 quarterly MDS assessment revealed the resident's pain had increased to moderate every day. Review of the physician orders recapitulation for October 2008 revealed an order to assess the resident's pain level twice daily using a scale of 1-10. Review of the October 2008 physician order flow sheet revealed there was no evidence a pain assessment was performed twice daily on 15 days. In addition, review of the November 2008 physician order flow sheet revealed there was no evidence a pain assessment was performed twice daily on 11 of 16 days to date. Interview with the director of nursing (DON) on 11/19/08 at 10:10 AM revealed she was aware there was a problem in documenting pain assessments and improvement in this area was needed. 2. Review of the 6/2/08 annual and the 9/1/08 quarterly MDS assessments for resident #39 revealed s/he experienced edema (leg) and mood issues expressed by making negative statements and exhibiting verbal distress. Review of the	F 281	F 281 483.20(k)(3)(i) 1. Resident 18 has been assessed for pain and is receiving pain medication as needed. Nursing staff will be in serviced related to required assessment per physician orders and accurate and complete documentation. 2. Resident 39 has been assessed for pain and edema per physician orders. Resident 39 has also been assessed for mood and behaviors. The social services director will follow up with resident 39 as indicated by mood and behavior assessment. 3. Resident 7 has been assessed for pain and is receiving pain medication as needed. Further assessment will be completed and documented per physician orders.	1/15/09

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F 281	Continued From page 7 October 2008 physician's order recapitulation revealed an order dated 4/2/08 to monitor lower extremity edema and a 6/18/08 order to monitor the resident's mood. Review of the October 2008 and November 2008 physician order flow sheets and of the nursing notes revealed there was no evidence these orders were carried out. Interview with the DON on 11/19/08 at 10:10 AM revealed she was aware there was a problem with staff documenting pain assessments and she was "working on it." 3. Review of the 1/11/08 annual and the 7/7/08 and 10/8/08 quarterly MDS assessments for resident #7 revealed s/he experienced moderate pain less than daily. Review of the physician's order dated 4/29/07 revealed staff should assess the resident's pain level twice daily using a scale of 1 to 10. Review of the November 2008 physician order flow sheet revealed the resident's pain level was not assessed twice daily on 12 of 16 days. Interview with the DON on 11/19/08 at 10:10 AM revealed she was aware there was a problem with staff documenting pain assessments and she was "working on it." 4. Record review of the 10/08/2008 physician's progress notes for resident #49 revealed the physician ordered a Flovent inhaler twice a day for treatment of chronic obstructive pulmonary disease. The following concerns were identified: a. Review of the resident's November 2008 medication administration record (MAR) showed the medication was scheduled to be given at 8:00 AM and 8:00 PM. Observation on 11/16/08 at 7:40 AM revealed registered nurse (RN) #1 did not administer the resident's PM dose of Flovent inhaler because the RN could not find the medication.	F 281	F281 Cont. 4. Resident 49 is receiving the Flovent inhaler twice daily as ordered. The medication is stored in the medication cart. All licensed nurses will be educated related to required assessment per physician orders and accurate and complete documentation. All licenses nurses will be educated related to proper storage and administration of medications. The DON/designee will perform random audits of pain assessments, behavior and mood assessment, medication administration records, and medication passes. The results of these audits will be presented at monthly QA meetings for 3	1/15/09

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F 281	Continued From page 8 b. Interview on 11/17/08 at 9:30 AM with licensed practical nurse (LPN) #2 revealed she found the medication in the resident's beside stand drawer, administered the 11/17/08 AM dose and put it back in the drawer. The LPN said the nurses periodically left the medication in the resident's room. The LPN did not give an explanation for why the nurses continued to leave the medication in the resident's room when they knew the physician did not order self medication administration for the resident. c. Review of the nurses' documentation on the MAR revealed the Flovent was administered as ordered on 11/17/08 and at 8:00 AM on 11/18/08, but the PM dose on 11/18/08 and AM dose on 11/19/08 was not administered because it was unavailable. d. Interview on 11/19/08 at 11:00 AM with RN #2 revealed she did not administer the 11/19/08 AM dose of the medication because s/he could not find it. The RN said she did not look in the resident's room because the physician did not order self medication administration for the resident and it should not be in the resident's room. e. Interview on 11/19/08 at 11:30 AM with the DON revealed expectations that all nursing staff should follow acceptable standards of nursing practice for ensuring medication administration according to physician's orders.	F 281	months and quarterly thereafter. Monthly reports will continue for negative outcomes of audits.	11/25/08
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		11/25/08

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F 282	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan was followed for five (#7, #11, #18, #19, #45) of 12 sample residents. The findings were:; 1. Review of the 10/6/08 quarterly Minimum Data Set (MDS) assessment for resident #7 revealed s/he was easily annoyed and exhibited anger about being placed in a nursing home. Review also revealed the resident persistently sought medical attention by having repetitive health complaints. Review of the previous 7/7/08 quarterly MDS assessment revealed the resident had no mood and behavior patterns. Review of the 10/9/08 care plan revealed the resident was at risk for altered mental status, mood, and behavior related to his/her environment/lifestyle changes with placement in the nursing home. Further review of the care plan revealed staff should monitor and record changes in mood/behavior. However, review of the October 2008 and November 2008 monthly flow record revealed the only issue monitored was the resident's sleeplessness, not mood or behavior. Interview with the director of nursing (DON) on 11/19/08 at 10:10 AM confirmed the resident's mood and behaviors had deteriorated since his/her admission to the facility on 4/29/07. 2. Review of the 9/29/08 care plan for resident #18 revealed s/he had a visual impairment and one of the interventions was to announce yourself when entering the room. However, observation on 11/16/08 at 7:12 PM revealed certified nurse aide (CNA) #2 entered the room without knocking or announcing herself. Interview with the resident on	F 282	F 282 483.20(k)(3)(ii) 1. Resident 7 has had the required assessment for mood and behaviors added to the daily scheduled required assessment. Any observed behaviors will be documented and patterns of behaviors will be referred to the social services director for discussion and recommendation of intervention by the interdisciplinary team.	1/13/09

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THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 282	Continued From page 10 11/18/08 at 2:48 PM revealed s/he did not like having staff enter the room without knocking or announcing themselves first. 3. Review of the 11/6/08 initial MDS assessment for resident #45 revealed s/he had experienced a fall in the past 30 days and a fracture in the past 180 days. Review of the 11/13/08 care plan revealed the resident was at risk for falls. Further review revealed one of the interventions was for a motion monitor to his/her wheelchair. Review of the 11/16/08 timed at 10:30 AM nursing notes revealed an activity staff member observed the resident fall out of his/her wheelchair. Further review of those notes revealed the motion monitor was not on the resident's wheelchair at the time of the fall. 4. Review of the 10/20/08 care plan for resident #19 revealed an approach for incontinence care was to assist with toileting upon rising, before meals, after meals, at bedtime during the day. Observation of the resident on 11/18/08 from 6:00 until 9:00 PM revealed the resident remained in his/her wheelchair and staff did not assist the resident to the bathroom or check and change his/her brief. At 9: 00 PM, the certified nurse aide (CNA) #1 removed the resident's urine saturated brief. Interview with the CNA revealed the CNA was aware of the care plan approach for incontinent care, but the CNA was too busy with other duties to provide the assistance the resident needed. 5. Review of the 10/28/08 care plan for resident #11 revealed an approach for incontinence care was assist/ encourage to toilet upon rising, before and after meals, at bedtime and when necessary during the day. Observation of the resident on	F 282	2. Resident 18 has been assured that staff will announce themselves prior to entering her room. Resident 18 stated that she would be happy with this outcome. All staff will be educated related to the need to announce themselves prior to entering all resident rooms. 3. Resident 45 has been assessed for fall risk. This resident is at risk for falls and the motion monitor is to be attached to the resident when in his/her wheelchair. All staff will be educated related to the need to attach motion monitors to all residents at risk for falls. All staff will also be educated to be aware of residents with motion monitors and to make sure that they are attached to the resident. 4. Resident 19 continues with the current approach for incontinence care.	11/15/09

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F 282	Continued From page 11 11/18/08 from 6:00 until 8:25 PM revealed the resident remained in his/ her wheelchair in the TV/ lobby area and asked staff for assistance to the bathroom at 7:35 PM and again at 8:15 PM. Further observation revealed staff ignored the resident's request until 8:25 PM, then CNA #1 wheeled the resident to the resident's room and removed the resident's urine saturated brief. Interview with the CNA revealed the CNA was aware of the care plan approach for incontinent care, but the CNA was too busy with other duties to provide the assistance the resident needed.	F 282	F 282 cont. Nursing staff will be educated related to the need and expectation to follow resident care plans. 5. Resident 11 will continue with the same approach for incontinence care. Nursing staff will be educated to the need and expectation to follow resident care plans. The DON/designed will perform random audits of behavior sheets, resident dignity (knocking on doors and announcing self prior to entering resident rooms), placement of motion monitors, and incontinence care per written care plans. The results of these audits will be presented at monthly QA meetings for 3 months and quarterly thereafter. Any audits that reveal	11/15/08
F 309 SS=E	483.25 QUALITY OF CARE 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff provided necessary care and services for 4 (#19, #39, #42, #45) of 12 sample residents. The findings were: 1. Review of the 9/1/08 quarterly MDS assessment for resident #39 revealed s/he had sustained a fall during the past 31 to 180 days. Review of the fall risk assessment performed on 6/2/08 revealed the resident was a high risk for falls. Review of the nursing notes revealed the resident sustained a fall on 7/19/08. Review of the entire medical record and the incident reports revealed there was no evidence the cause of the	F 309		11/15/08

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F 309	Continued From page 12 fall was evaluated. 2. Review of the 11/6/08 initial MDS assessment for resident #45 revealed s/he had experienced a fall in the past 30 days and a fracture in the past 180 days. Review of the 11/13/08 care plan revealed the resident was at risk for falls. Further review revealed one of the interventions was for a motion monitor to his/her wheelchair. Review of the 11/16/08 timed at 10:30 AM nursing notes revealed an activity staff member observed the resident fall out of his/her wheelchair. Further review of those notes revealed the motion monitor was not on the resident's wheelchair at the time of the fall. 3. Review of the 10/03/08 physician history and physical report for resident #19 revealed the resident was discharged to the facility after recovering from surgery for a fractured hip which occurred when the resident fell on 9/11/08. Further review of the 10/3/08 physician history and physical report revealed the resident had a second surgery on the same hip due to an injury resulting from a fall at the facility on 10/3/08. Review of the October and November 2008 certified nurse aide and nurses notes for the resident revealed the resident returned to the facility on 10/7/08 and the resident fell again on 10/25, 11/2, 11/3, 11/10/08 and 11/14/08. Review of the resident's plan of care updated on 10/27/08 revealed staff did not make changes in the resident's care related to the recurrent falls. Review of the resident's medical record revealed staff did not complete a post fall assessment after each fall to identify precipitating factors related to the patient's recurrent falls. Interview on 11/17/08 at 2:10 PM with licensed practical nurse (LPN) #2 confirmed the lack of a system.	F 309	F 282 cont. noncompliance with the care plan will be again entered in the QA minutes. F 309 483.25 1. Resident 39 will have a fall risk assessment completed. Appropriate interventions will be instituted and/or continued. 2. Resident 45 will have a fall risk assessment completed. Appropriate interventions will be instituted and/or continued. 3. Resident 19 will have a fall risks assessment completed. Appropriate interventions	1/15/09 1/15/09

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F 309	Continued From page 13 4. According to the July to November 2008 nurses notes for resident #42, the resident fell to the floor on 7/15, 7/16, 9/17, 9/29 and 11/16/08. Review of the July 2008 nurse's notes revealed the resident was hospitalized for a pelvic fracture that resulted from the 7/15 and 7/16/08 fall. Review of the resident's medical record revealed the lack of a post fall assessment to determine the precipitating factors related to the resident's recurrent falls. Interview with registered nurse (RN) #2 and LPN #1 on 11/19/08 at 2:40 PM confirmed the lack of a post fall assessment.	F 309	F 309 cont. 4. Resident 42 will have a fall risk assessment completed. Appropriate interventions will be instituted and/or continued. A fall risk committee will be established. Members will be the DON/designee, restorative nurse, physical therapy. Each fall will be discussed and assessed the day after the fall. The fall risk committee will request orders from the physician for any new recommendation or intervention. A post fall risk assessment will be completed by the charge nurse at the time of the fall. Any immediate needs for Safety measures will be instituted by the charge nurse at that time as an emergency measure.	1/15/09
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 staff performed perineal care after an episode of incontinence for one (#18) of 12 sample residents. The findings were: Observation on 11/16/08 at 6:50 PM revealed resident #18 was incontinent of urine. Continued observation revealed the certified nurse aide (CNA) #1 did not perform any perineal care for the resident whose incontinence brief, slacks and wheelchair cushion were saturated with urine. During an interview with the CNA on 11/16/08 at 6:50 PM, she stated although sometimes the resident refused peri-care, staff were instructed to	F 312		1/15/09

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F 312	Continued From page 14 offer after each episode of incontinence. Observation at the time of the incident revealed the CNA did not offer to provide or assist with perineal care. Interview with the CNA revealed she should have offered. Interview with the resident on 11/18/08 at 2:48 PM revealed s/he did not mind having the CNAs provide perineal care when needed. Based on confidential interview with residents on 11/17/08 at 3 PM, a concern identified was that not all residents received baths or showers as scheduled; specifically residents #7, #18 and #45. The findings were: 1. Review of the 6/16/08 initial and the 9/15/08 quarterly MDS assessment for resident #18 revealed s/he required limited assistance of one for bathing. Review of the ADL (activities of daily living) flow record revealed this resident received no baths from 9/1/08 until 9/9/08 (8 days), from 9/20/08 until 9/30/08 (10 days), and from 10/25/08 until 11/4/08 (10 days). Interview with the resident revealed s/he wanted a bath/shower twice weekly. Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly. 2. Review of the 1/11/08 annual and the 7/1/08 and 10/6/08 quarterly MDS assessments for resident #7 revealed s/he required extensive assistance of one for bathing. Review of the ADL flow record revealed there was no evidence the resident received a bath/shower from 10/18/08 until 10/27/08 (9 days). Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly.	F 312	The fall risk committee will then assess the incident report and either continue the intervention or make recommendations to the physician for appropriate additional safety measures. The DON/designee will review each incident report for accuracy and completeness. Random audits will performed of fall risk assessment, incident reports, and post fall interventions. The DON/designee will also keep minutes of the fall risk committee meetings. The minutes of these meetings and the results of audits will be presented at monthly QA meetings for 3 months and quarterly on an as needed basis thereafter.	11/19/08

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F 312	Continued From page 16 3. Review of the 11/6/08 initial MDS assessment for resident #45 revealed s/he required total assistance of one for bathing. Review of the ADL flow record revealed there was no evidence the resident received a bath/shower from 10/25/08 through 11/15/08 (21 days). Interview with a family member on 11/26/08 at 2:50 PM revealed s/he was unsure how often or when the resident received a bath/shower. The family member stated s/he knew no baths/showers were given on the weekends. Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly.	F 312	F 312 483.25(a)(3) Resident 18 has been provided with one on one visits by the activity director. The resident has expressed no further concerns related to the incident of 11/06/2008. The CNA involved in the incident has been educated related to the necessity of offering peri-care to all residents that require assistance with toileting. 1. Resident 18 has been reassured that he/she will receive baths twice weekly. 2. Resident 7 has been reassured that he/she will be bathed twice weekly. 3. Resident 45 has been reassured that he/she will be bathed twice weekly.	11/15/08
F 315 SS=G	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure staff provided toileting assistance in a timely fashion for 3 (#11, #18, #19) of 12 sample residents. The lack of timely assistance resulted in harm for one (#18) resident who experienced an incontinence episode when s/he was usually continent. The findings were:	F 315		11/15/08

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F 315	Continued From page 16 1. Review of the 6/16/08 initial Minimum Data Set (MDS) assessment for resident #18 revealed s/he was usually continent. Review of the 9/15/08 quarterly MDS assessment revealed s/he was frequently incontinent but still retained some control. Review of both MDS assessments revealed the resident required limited assistance of one for toileting and personal hygiene. Further review of the two MDS assessments revealed the resident was cognitive, and independent in decision making skills, was understood and able to understand. Review of the 9/22/08 care plan revealed the resident was usually continent of bladder and interview with the director of nursing on 11/19/08 at 10:10 AM revealed the resident was usually continent of urine. The following concerns were identified: a. Interview with the resident on 11/16/08 at 6:40 PM revealed s/he had asked a certified nurse aide (CNA) to assist him/her to the toilet for urination around 6:10 PM but was told by the CNA that the resident must wait until all residents were assisted from the dining room. b. Observation on 11/16/08 at 6:50 PM revealed the resident turned on the call light and again requested assistance to use the toilet. At that time, CNA #1 assisted the resident to the toilet where observation revealed the resident's slacks, incontinence brief, and wheelchair cushion was saturated with urine. In addition, observation revealed a puddle of urine was on the floor where it had run off the wheelchair cushion. Interview with CNA #1 on 11/16/08 at 6:50 PM revealed she had to wait to toilet the resident until all residents were out of the dining room. Interview with the resident on 11/16/08 at 2:48 PM revealed s/he was humiliated over the incident.	F 315	F 312 cont. All nursing staff will be educated related to the need to follow the bath schedule and the necessity of accurate and complete documentation. The charge nurses will be instructed that it is necessary to insure that baths are completed as scheduled. The DON/designee will perform random audits of the bath schedule and the documentation of completed baths. The results of these audits will be presented at monthly QA meetings for 3 months and quarterly thereafter. Any irregularities will be again added to the QA agenda.	1/15/09

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F 315	Continued From page 17 c. Interview with the DON on 11/19/08 at 10:10 AM revealed this resident took great pride and joy in his/her appearance. She further stated this incident must have been "very hard on the resident." d. Observation and review of the staffing schedule revealed there were two CNAs on the evening/night shift on 11/16/08 for 37 residents. 2. Review of the 10/20/08 admission Minimum Data Set (MDS) assessment revealed resident #19 uses a wheelchair for locomotion, has multiple daily episodes of bowel and bladder incontinence and requires total assistance with toileting and personal hygiene care. Review of the 10/20/08 care plan revealed an approach for incontinence care was to assist with toileting upon rising, before meals, after meals, at bedtime during the day. Observation of the resident on 11/16/08 from 6:00 until 9:00 PM revealed the resident remained in his/ her wheelchair and staff did not assist the resident to the bathroom or check and change his/ her brief. Further observation at 9: 00 PM revealed the certified nurse aide (CNA) #1 removed the resident's urine saturated brief. Interview with the CNA revealed direct care staff had been instructed to assist the resident with toileting after meals, but the CNA was too busy with other duties to provide the assistance the resident needed. 4. Review of the 10/21/08 bowel and bladder assessment revealed Resident #11 was frequently incontinent of bladder, at times aware of own toileting needs and requires assistance with toileting upon rising, before meals, after meals, at bedtime and when necessary. Observation of the resident on 11/16/08 from 6:00 until 8:25 PM revealed the resident remained in	F 315	F 315 483.25(d) 1. Resident 18 will be reassessed for incontinence and assistance required. He/she will be toileted and assisted with care as the assessment indicates. Resident 18 and all other residents will be toileted per the care plan and in a timely manner. 2. Resident 19 will be reassessed for incontinence and assistance required. He/she will be toileted and assisted with care as the assessment indicates. 4. Resident 11 will be reassessed for incontinence and assistance required. He/she will be toileted and assisted with care as the assessment indicates.	11/19/09

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F 315	Continued From page 18 his/ her wheelchair in the TV/ lobby area and asked staff for assistance to the bathroom at 7:35 PM and again at 8:15 PM. Further observation revealed staff ignored the resident's request until 8:25 PM, then CNA #1 wheeled the resident to the resident's room and removed the resident's urine saturated brief. Interview with the CNA revealed the resident had the ability to remain continent when staff assisted the resident to the bathroom at the time the resident requested, but the CNA was too busy with other duties to assist the resident in a timely manner.	F 315	All nursing staff will be educated related to care plans, incontinence care, toileting schedules and toileting as requested by the residents. The nursing staff will also be instructed that it is not acceptable to instruct a resident that they must wait for assistance with toileting until another task is completed unless that task is completing care for another resident. The DON/designee will conduct random audits of toileting per care plans, toileting upon request and incontinence care. The results of these audits will be presented at monthly QA meetings for 3 months and quarterly thereafter. If a problem is discovered with those audits the problem will again be added to the QA agenda and further education provided.	1/15/09
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an environment free of accident hazards in four of seven resident hallways and the main resident dining room. The findings were: Observations over four days of survey revealed potential accident hazards in four (A, F, E, SCU) of seven resident hallways, as well as in the main resident dining room. The following deficiencies were noted: 1. Sections of the handrails in hallways F and the special care unit (SCU) were missing end caps or	F 323		1/15/09

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F 323	Continued From page 19 the existing end caps were cracked, resulting in abrupt edges along the handrails. Residents in the SCU were observed to use the handrails to assist ambulation and wheelchair mobility. 2. Baseboard heaters in resident hallways A, E, F, the main dining room, and the bath/shower room in hallway A presented sharp and abrupt edges where they had been bent or dented. An additional heater located beneath the fireplace in the main resident dining room was missing the end cap assembly and presented a sharp edge in a high trafficked area. Interview with the maintenance supervisor on 11/19/08 at 10:40 AM confirmed the condition of the handrails and baseboard heater covers. He stated a plan to systematically repair or replace the heaters. The supervisor added the cost of the activity continued to delay its completion.	F 323	F 323 483.25(h) 1. New handrails have been ordered and will be installed as soon as they are delivered to the building. 2. All baseboard heaters have been evaluated for sharp or missing parts. They will be repaired or replaced to insure safety for residents and staff.	1/15/09
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	The Administrator, the /DON and the Maintenance Director will conduct weekly rounds and audits. The results of these rounds will be presented at the monthly QA meetings. Any noted problems will be repaired immediately.	1/15/09

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THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 329	Continued From page 20 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 staff interview and medical record review, the facility failed to ensure unnecessary medications were not administered to one (#18) of 12 sample residents. The findings were: Review of the October 2008 physicians's order recapitulation for resident #18 revealed an order for Ambien 2.5 milligrams at bedtime for sleep. Review of the medical record revealed no evidence of an assessment to determine the cause of the resident 's inability to sleep nor what non-pharmacological interventions were attempted. Interview with the director of nursing on 11/19/08 at 10:10 AM revealed she was unable to find evidence a sleep assessment was performed.	F 329	F 329 483.25(i) Resident 18 will be assessed for non-pharmacological interventions that may induce sleep without medication. Resident 18 will have a sleep assessment completed. Nursing staff will be educated related to the need to complete assessment as indicated by psychotropic medication orders. Nursing staff will also be educated related to the need to attempt reduction of psychotropic medications. Assessment of non-pharmacological intervention attempts and results will be reviewed at psychotropic meetings. Physicians will be notified of the need to attempt psychotropic medication reduction.	11/5/09
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		11/5/09

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F 353	Continued From page 21 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans; Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure there was an adequate number of staff to provide the necessary care and services for a census of 50 residents; specifically for three (#7, #18, #45) of 12 sample residents The findings were: 1. Review of the 6/16/08 Initial Minimum Data Set (MDS) assessment for resident #18 revealed s/he was usually continent. Review of the 9/15/08 quarterly MDS assessment revealed s/he was frequently incontinent but still retained some control. Review of both MDS assessments revealed the resident required limited assistance of one for toileting and personal hygiene. Further review of the two MDS assessments revealed the resident was cognitive, and independent in decision making skills, was understood and able to understand. Review of the 9/22/08 care plan revealed the resident was usually continent of bladder and interview with the director of nursing on 11/19/08 at 10:10 AM revealed the resident	F 353	The DON/designee will perform random audits of psychotropic medication usage. The results of these audits will be presented at monthly QA meetings for 3 months and quarterly thereafter. Any problems identified during the audits will be placed on the monthly QA agenda until the problem has been resolved. F 353 483.30(a) 1. See F 312 and F 315 2. See F 312 and F 315 3. See F 312 and F 315 the evening schedule has been adjusted to schedule 4 – 5 CNAs on the evening shift. (2 pm – 10 pm)	1/15/09 1/15/09

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F 353	Continued From page 22 was usually continent of urine. The following concerns were identified: a. Interview with the resident on 11/16/08 at 2:48 PM revealed s/he had asked a certified nurse aide to assist him/her to the toilet for urination but was told by the CNA that the resident must wait until all residents were assisted from the dining room. b. Observation on 11/16/08 at 6:50 PM revealed the resident turned on the call light and again requested assistance to use the toilet. At that time, CNA #1 assisted the resident to the toilet where observation revealed the resident's slacks, incontinence brief, and wheelchair cushion was saturated with urine. In addition, observation revealed a puddle of urine was on the floor where it had run off the wheelchair cushion. Interview with CNA #1 on 11/16/08 at 8:50 PM revealed it was difficult to meet every resident's needs when there were only two CNAs on duty. Observation and review of the staffing schedule revealed there were two CNAs on the evening/night shift on 11/16/08 for 37 residents. Based on confidential interview with residents on 11/17/08 at 3 PM, a concern identified was that not all residents received baths or showers as scheduled; specifically residents #7, #18, and #45. The findings were: 1. Review of the 6/16/08 initial and the 9/16/08 quarterly MDS assessment for resident #18 revealed s/he required limited assistance of one for bathing. Review of the ADL (activities of daily living) flow record revealed this resident received no baths from 9/1/08 until 9/9/08 (6 days), from 9/20/08 until 9/30/08 (10 days), and from 10/26/08 until 11/4/08 (10 days). Interview with the resident revealed s/he wanted a bath/shower	F 353	4. The bath schedule has been adjusted to provide baths 5 day per week. All residents will receive at least 2 baths per week. 5. The total assist feeding tables will be staffed with a total of 3 – 4 CNAs at each meal. Nursing staff will be in-serviced related to answering call lights in a timely manner, providing baths per the bath schedule, feeding residents that require total assist or extensive cueing and appropriate appropriate toileting of residents.	1/15/09

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F 353	Continued From page 23 twice weekly. Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly. 2. Review of the 1/11/08 annual and the 7/1/08 and 10/6/08 quarterly MDS assessments for resident #7 revealed s/he required extensive assistance of one for bathing. Review of the ADL flow record revealed there was no evidence the resident received a bath/shower from 10/18/08 until 10/27/08 (9 days). Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly. 3. Review of the 11/6/08 initial MDS assessment for resident #45 revealed s/he required total assistance of one for bathing. Review of the ADL flow record revealed there was no evidence the resident received a bath/shower from 10/26/08 through 11/15/08 (21 days). Interview with a family member on 11/20/08 at 2:50 PM revealed s/he was unsure how often or when the resident received a bath/shower. The family member stated s/he knew no baths/showers were given on the weekends. Review of the bath/shower schedule provided by the facility revealed this resident was scheduled for a bath or shower twice weekly. 4. Interview with the DON on 11/19/08 at 10:10 AM revealed there were two bath aides but they do not provide baths/showers every day of the week. 5. Observation on 11/18/08 at 5:55 PM revealed six residents at one table and two residents at the second table were receiving assistance with their	F 353	The DON/designee will perform random audits of the bath sheets, call lights, scheduling, and feeding of residents. The results of this audit will be presented at monthly QA meetings for 3 months and quarterly thereafter. Any audits that reflect areas of concern will be placed on the monthly QA agenda until the problem is resolved.	1/13/09

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F 363	Continued From page 24 evening meal. Interview with certified nurse aides CNA #1 and CNA #2 revealed the eight residents required extensive and total assistance with eating. Observations from 5:55 to 6:55 PM revealed the two CNAs moved from table to table and from resident to resident trying to provide the assistance the eight residents needed. Continued observation revealed some of the residents dozed and some of the residents spilled food while they waited for the CNAs to give them an additional spoonful of food, sip of fluids or verbal cues. Observation at 6:55 PM when the residents finished the meal revealed the residents consumed one half or less of their food.	F 363	F 371 483.35(i) 1.a. The health shake was discarded. 1.b. The floor of the dry goods storage area has been thoroughly cleaned. The fan grate in the dry goods storage area has been cleaned. 1.c. The insulated food transport cart has been thoroughly cleaned. 1.d. The open glass was removed from the area and the contents discarded. 1.e. The 2 jars of fruit jelly were discarded. 2. a. The dietary staff has been educated related to the necessity of insuring that nothing touches the food or dishes that is not clean	11/15/09
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/15/09
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and standards of practice for sanitary food preparation, the facility failed to ensure dietary staff stored, prepared, and distributed food to residents in a sanitary manner for two of two meal preparations observed. The findings were: Repeat observation of the dietary staff, food storage facilities, and meal service during four days of survey revealed the following deficiencies:			

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F 371	Continued From page 25 1. Observation during the initial tour of the kitchen on 11/16/08 at 4:45 PM revealed unsanitary conditions in the kitchen. a. An open health shake was observed in the walk-in refrigerator. The carton was half full from previous use and left on a shelf; the spout was opened and there was not labeling to indicate the date the carton was first opened. Interview with Cook #2 revealed the resident only drinks half of the health shake contents at a meal and the remainder is kept for the following meal. She confirmed proper storage required the carton to be closed and labeled with the date opened. b. Debris and dried liquid spills were observed on the floor of the dry goods storage area, initially on 11/16/08 at 5:10 PM. At the same time, the grating covering an exhaust fan mounted in the dry goods area was also observed to be dirty with dust covering 90% of the exposed surface area. Repeat observation revealed both the floor and exhaust fan remained dirty through 11/19/08 at 9:30 AM. c. Food crumbs and dried food particles were observed inside an insulated cart used to transport food trays to the special care unit (SCU). d. An open glass containing a brown beverage was observed on the counter adjacent to the only hand washing station in the kitchen. The glass was positioned directly beneath the soap dispenser. Dietary aide #2 stated the glass was her personal drink. e. Two jars of fruit jelly were observed on a shelf in the dry storage area at room temperature. Both jars had previously been opened and the contents partially used. The label on each jar stated the contents were to be refrigerated after opening.	F 371	Name tags are to be worn in the area of the uniform that will not come in contact in food or dishes. 2. b. The dietary staff has been educated related to the necessity of that no dishes are to be placed near the hand washing station and no personal food items will be consumed during the service or preparation of food. 2.c. The dietary staff has been educated related to proper handling of [illegible] containers and [illegible] hand washing after touching environmental surfaces. They have also been educated related to the need to change gloves and hand washing.	11/15/08

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F 371	Continued From page 28 2. Food preparation was observed for two meals, breakfast on 11/17/08 and lunch 11/18/08. The following deficiencies were observed: a. On 11/17/08 Cook #1 was observed to use a foot stool in order to reach clean dishes on a shelf above the steam table in the kitchen. Twice she picked up the stool with her bare hands to move it closer to the serving line; each time touching the area her feet stood upon. The cook then handled clean bowls and dishes, not washing her hands over the 37 minute observation period. The cook as later observed to reach across the serving line for pans on the back of the steam table; on each of four occasions her name tag was observed to drag across plates on the serving line contain resident food. The plates were placed onto trays and served to residents in the main dining room. b. On 11/17/08 a coffee cup was observed on the counter adjacent to the hand washing sink in the kitchen. Dietary aide #3 stated the coffee was hers and she was observed to drink and refill the open cup. On one occasion, the aide moved her coffee cup to the counter in the dining room adjacent to the serving window; she was observed to drink from the cup on two occasions while preparing and serving trays. c. On 11/17/08, dietary aide #1 was observed while preparing residents trays for the breakfast meal. The aide carried a large plastic juice pitcher by placing one hand on the handle and the other hand on the pouring spout. She further lifted bowls containing dry cereal by placing her thumb inside the bowl, contacting the cereal. The aide also handed a spoon to the cook, holding the eating surface in her hand. The cook used the spoon to mix pureed food prior to serving to residents. The aide repeatedly touch common environmental surfaces (counter top, cabinets and drawers, refrigerator handle, glassware, food	F 371	2.d. The dietary staff has been educated related to the proper transport of food items from any storage area to the kitchen. A cart is now used to bring food from the outside storage area. 3. A policy is in place regarding the staff food and drink in the food preparation or food service area. The dietary staff has been educated on the above items. A policy has been put in place regarding staff food or drink in a food preparation or food service area. The Dietary Manager/designee will conduct random audits of the above and present the findings at monthly QA meetings for 3 months. The dietary manager/designee will continue random audits and present those results at quarterly QA meetings.	11/3/09

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F 371	Continued From page 27 trays) over a 28 minute observation period and was not seen to wash her hands. d. On 11/18/08, Cook #2 was observed going to an outside storage freezer. She retrieved three bags of frozen vegetables and put the bags on the ground while replacing the padlock on the freezer door. The cook returned inside to the kitchen and placed the vegetables on the counter adjacent to the range. 3. Interview with the dietary manager on 11/19/08 at 9:40 confirmed the floor and fan should have been cleaned regularly, stating staff are scheduled to clean the storage area twice a week. Further, she confirmed the health shake and fruit jellies were improperly stored and stated she had disposed of both items. The manager also stated her expectation staff should not have an open (no lid or straw) drink in the food preparation area, nor should food be placed on the ground. The manager stated the facility did not have written policies regarding employee food or drink in the kitchen. 4. The U.S. Food & Drug Administration Food Code requires compliance with the following practices with regard to eating and drinking in food preparation area (excerpt from US Food Code, 2005): 2-401.11 Eating, Drinking, or Using Tobacco. (A) Except as specified in (B) of this section, an EMPLOYEE shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection can	F 371		1/18/08

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F 371	Continued From page 28 not result. (B) A FOOD EMPLOYEE may drink from a closed BEVERAGE container if the container is handled to prevent contamination of: (1) The EMPLOYEE'S hands; (2) The container; and (3) Exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.	F 371	F 431 483.60(b)(d)(e) All expired medications have been removed from the medication carts and discarded per facility policy. All medication carts will be reviewed for expired medication on a monthly basis. This duty will be assigned to the charge nurses. Nursing staff has been educated related to the correct method of disposing of expired medications and reviewing medication carts for expired medication (prescribed, OTCs, and controlled). The	11/15/08
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431		11/15/08

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F 431	Continued From page 29 Control Act of 1976 and other drugs subject to 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 review of stored medications and staff interview, the facility failed to assure expired medications were removed from two of two medication carts. The findings were: Observation on 11/18/08 at 10:25 AM of the second medication cart located in the special care unit revealed the expired date on a sixteen ounce bottle of floor stock milk of magnesium was 9/10/08. Interview with licensed practical nurse (LPN) #1 revealed the facility did not have a system for discarding expired medications. Observation on 11/18/08 at 10:40 AM of the first medication cart on the nursing unit revealed resident #12 Vicodin expired on 4/22/08 and resident #1 Vicodin expired on 10/6/08. Review of the November 2008 controlled drug administration record revealed the nurses administered expired medications to resident #12 on 10/30/08 and to resident #1 on 11/12/08. Interview with LPN #2 revealed the facility's system for checking expired medications was totally dependent on the monthly pharmacy reviews and did not include a routine check by the nursing staff.	F 431	DON/designee will conduct [redacted] random audits and the results will be presented at monthly QA meetings for 3 months. After the 3 month period random audits will be continued with results presented at quarterly QA meetings. [redacted]	1/15/0
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a	F 441		

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F 441	Continued From page 30 safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control surveillance records and policies and procedures, the facility failed to maintain accurate and timely infection control surveillance records for four of nine months sampled. The facility further failed to ensure staff followed appropriate infection control practices when passing medications, distributing ice to residents, using hand washing facilities, and assisting residents with personal care and dressing. The findings were: 1. Review of the facility's infection control surveillance records for March through November 2008 (nine months) on 11/18/08 at 3:20 PM revealed data were incomplete or inaccurate on four of the nine monthly log sheets. The following issues were discovered: a. Surveillance records for March, April, September and November 2008 were incomplete in one or more areas of data collection. Seventeen of twenty resident infections listed on the surveillance documents failed to track either the infection or antimicrobial treatment to final resolution. b. Resident #52's medical record was	F 441	F 441 483.65(a) 1. The facility infection tracking procedure has been updated to include tracking of on-going infections. All infections will also be tracked for the antibiotic prescribed, labs if ordered, and date of resolution of infection. The ADON is now assigned to be the Infection	1/15/09

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	535051	A. BUILDING _____ B. WING _____	C 11/19/2008

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F 441	Continued From page 31 reviewed on 11/18/08 at 4:20 PM and revealed the resident's urine culture results on 5/2/08 was reported by the laboratory as positive for a hemolytic Staphylococcus bacterium and the physician ordered antibiotic treatment for the resident's urinary tract infection (UTI). Neither the May or June 2008 surveillance logs included any information regarding resident #52's UTI or antibiotic therapy. c. Interview with the director of nursing (DON) on 11/19/08 at 11:30 AM confirmed that resident #52 "was forgotten," and should have been included in the surveillance records for May 2008. The DON said documentation in the surveillance log might not be completed for several weeks after the facility received information about a positive culture. The DON further stated she tried to do the surveillance log, but it was difficult to this in addition to her other duties. 2. Observation of licensed practical nurse (LPN) #1 on 11/16/08 at 4:30 PM and again on 11/17/08 at 4:40 PM revealed the LPN was administering medications with applesauce from an open container positioned on the medication cart. Continued observation revealed the LPN placed a glucometer (portable device used to measure glucose in a blood sample) on the medication cart next to the open container of applesauce after testing residents' blood glucose levels. Interview with the LPN on 11/17/08 at 4:40 PM revealed she was not aware of any infection control problems involved in placing food in contact with the blood glucose meter. 3. Observation on 11/16/08 at 7:50 PM revealed a partially full open ice chest was positioned on a cart in the middle of the hallway; staff were using the ice to prepare water for residents. Over the	F 441	F 441 cont. Control Nurse. The DON will be educated related to infection policy and tracking system. The Charge Nurses will be educated regarding proper documentation of infections and the need to provide the infection control nurse with copies of labs, physician orders, and date of infection resolution. 2. The nursing staff will be educated regarding the placement of any biohazardous material near any food or medication. 3. Nursing staff will be educated regarding the proper administration of ice water to residents including the necessity of covering the ice container after each cup is filled with ice. Nursing staff will also be educated	1/15/09

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F 441	Continued From page 32 next 20 minutes, residents were observed touching the opened ice chest as they wheeled or walked by it in the hallway, and at least three staff walked by the open ice chest and failed to close the lid on the chest. At 8:10 PM certified nurse aide (CNA) #1 covered the exposed ice with the ice chest lid. On 11/17/08 at 2:20 PM an ice chest was observed on a cart adjacent to the ice machine in the main hallway. Closer inspection revealed staff left a small ice scoop and plastic glass inside the ice chest. The scoop and glass were still stored inside the ice chest at 5:40 PM the same day. Interview with the dietary manager on 11/19/08 at 9:20 AM revealed her expectation that staff not store scoops or cups inside the ice machine or any ice chests used for residents' hydration. 4. Observations of hand washing stations in the kitchen (11/16/08) and dining room serving area (11/17/08) revealed inappropriate infection control practices. The findings were: a. The immediate area around the hand washing station in the kitchen included uncovered drinking glasses and cups used by the kitchen staff. On 11/16/08 at 4:45 PM a dietary aide placed her glass by the hand washing sink, leaving it directly beneath the wall-mounted soap dispenser. Three facility staff were observed to wash their hands between 4:45 PM and 5:10 PM; each reached their wet, unwashed hands over the aide's uncovered glass to access the soap dispenser. b. The hand washing sink in the main resident dining room had an opened box of gloves placed directly below a wall-mounted paper towel dispenser. On 11/17/08 at 8:15 AM three staff were observed to wash their hands; inspection of the area revealed water had dropped onto the	F 441	regarding the proper storage of ice scoops and glasses. 4. All staff will be educated regarding the necessity of not placing any food items, drink containers, or gloves near the hand washing stations or near paper towel dispensers. The hand washing area in the kitchen has been marked with red tape and nothing can be placed inside the red lines around the hand washing station. 5. Nursing staff has been educated regarding the need to insure that resident clothing and belongings are not placed on a soiled surface. The DON/designee will conduct random audits of infection control logs, placement of biohazardous	1/15/09

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F 441	Continued From page 33 gloves in the open box. At 8:35 (CNA) #4 removed gloves from the box, put them on her hands, and delivered food and drink to residents in the dining room. c. The dietary manager stated in interview on 11/18/08 at 2:30 PM her expectation that kitchen staff did not eat or drink in the kitchen. She confirmed the location of the glove box beneath the paper towel dispenser could lead to contamination of the gloves and disposed of the glove box in a trash can. Observation on 11/19/08 at 9:20 AM revealed a box gloves had again been placed beneath the paper towel dispenser in the main dining room. 5. Observation on 11/16/08 at 6:50 PM revealed certified nurse aide (CNA) #1 assisted resident #18 to the toilet; the resident's slacks, incontinence brief, and wheelchair cushion were saturated with urine. Observation revealed CNA #1 placed a clean incontinence brief and a clean nightgown on the resident's urine saturated wheelchair cushion while she assisted the resident to change out of his/her soiled wet clothing. Continued observation revealed the CNA retrieved the incontinence brief and nightgown from the wet cushion and placed these items on the resident on the resident. Interview with the CNA on 11/16/08 at 8:50 PM revealed she should not have placed clean clothes on the urine soaked cushion.	F 441	material near food [illegible] infection control [illegible] the proper usage and storage of ice water dispensing items, hand washing stations, and placement of resident belongings on soiled surfaces. The results of these audits will presented at monthly QA meetings. Audits will continue and the result will be presented at quarterly QA meetings.	1/15/08
F 444 SS=F	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	F 444		1/15/08

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F 444	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and professional standards for hand hygiene, the facility failed to require appropriate hand washing practices during one of two meal preparations observed and one of two meals observed in the special care unit (SCU). Further, the facility failed to ensure hand hygiene dispensers were operational for two of three locations. In addition, staff failed to practice appropriate hand hygiene during one of two perineal care observations. The findings were: 1. Kitchen staff observed during meal preparations on 11/17/08 at 7 AM failed to wash their hands after touching common environmental surfaces or contaminated items in the work area. a. Cook #1 was observed on 11/17/08 to pick up a foot stool on multiple occasion; her hands touched the step she had previously stood upon. The cook was not seen to wash her hands before touching clean plates, bowls, and serve food from the steam table. b. Dietary aide #2 was observed on 11/17/08 to repeatedly touch environmental surfaces (countertops, cabinet and drawers, refrigerator handle, juice dispenser levers, serving spoons and scoops) and retrieve a napkin from the kitchen floor while also serving food. The aide placed her thumb inside of bowls containing dry cereal while lifting them from a tray and on two occasions her thumb was seen to be in contact with the cereal. At no time during a 23 minute observation did the aide wash her hands. 2. Observations during the initial tour of the facility on 11/16/08 revealed two hand sanitizer gel	F 444	F 444 483.65(b)(3) 1. All staff will be educated regarding proper hand washing and glove usage. 2. The hand sanitizers have been refilled and repaired. All staff will be educated regarding monitoring hand sanitizer dispensers for proper operation and report and discrepancies to the house keeping department. 3. All nursing staff have been reeducated regarding proper hand washing techniques, proper glove usage, infection control related to any soiled surfaces. The DON/designee will perform random audits of above and present results of those audits at the monthly	1/13/10

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F 444	Continued From page 35 dispensers did not function correctly. A dispenser in the kitchen was discovered to be empty and a dispenser in the SCU was found to have a plugged spout. Facility staff in both locations stated they used the dispensers routinely, but none of the staff had reported the empty or nonfunctional devices. Both units were refilled by the housekeeping supervisor, 11/16/08 in the kitchen and 11/18/08 in SCU. 3. Observation on 11/16/08 at 6:50 PM revealed certified nurse aide (CNA) #1 assisted the resident to the toilet; the resident's slacks, incontinence brief, and wheelchair cushion was saturated with urine. Continued observation at this time revealed the CNA, without removing her soiled gloves, rifled through the resident's dresser drawer to obtain a clean incontinence brief and nightgown for the resident. After obtaining the clean items, the CNA went to the door of the room and opened it, also wearing the same soiled gloves. Interview with the CNA on 11/16/08 at 6:50 PM revealed she should have removed the gloves and washed her hands prior to looking through the resident's dresser drawer and touching the door knob..	F 444	QA meeting for [redacted]. Random audits will continue, and the results will be presented at quarterly QA meetings.	1/15/09
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe and sanitary environment for residents and staff in six of six	F 465		1/15/09

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F 465	Continued From page 36 hallways, the kitchen, or one of two outside patio areas. The findings were: Observation throughout the four day survey revealed the flooring in resident hallways A, B, C, E, F, and the special care unit (SCU) was excessively worn cracked, gouged, and separating along seams and previous repair sites. The gouges and cracks extended to the floor base and were not cleanable surfaces. Interview with the maintenance supervisor on 11/18/08 at 10:10 AM confirmed the poor condition of the flooring. He stated a plan to repair and replace the linoleum was under consideration, but had not been funded for completion. The housekeeping supervisor was present during the interview and added her opinion the floor was "...impossible to clean..." because of its condition. During the initial tour of the kitchen on 11/18/08 at 4:45 PM a multi-outlet box was observed in the dish machine room. A ventilation fan was plugged into the outlet box, the short cord from the fan caused the outlet box to be suspended about three feet from the ground and immediately adjacent to the outlet from the dish machine. Five of the six outlets in the box were open (unused) and facing toward the dish machine. Observation on 11/17/08 at 9:20 PM revealed the fan plug was not fully seated in the outlet box, exposing 1/4 inch of the two pronged plug. Further, the air in the dish room was damp and water droplets were present on the wall behind the dish machine as well as the wall where the multi-outlet box was hanging. The maintenance supervisor stated in interview on 11/19/08 at 10:40 AM he was aware of the multi-outlet box and its location alongside the dish machine. he state the outlet box was an interim solution to increase ventilation in the dish	F 465	F 465 483.70(h) The flooring in hallways A, B, C, E, and F and the Special Care Unit will be replaced. The material is on order and will be installed on arrival at the facility. The multi-unit outlet box has been replaced with a ground fault receptacle to accommodate the fan plug. The Administrator, DON, and/or maintenance supervisor will conduct weekly facility rounds to assure safety, infection control and compliance with federal regulations.	1/25/8 Jan. 29, 2008

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F 465	Continued From page 37 room, pending rewiring of the room to accommodate the fan plug. On 11/18/08 at 2:30 PM, a small dog was observed leaving the hair salon in the SCU hallway. The dog was allowed outside to go to the bathroom in the patio area for SCU residents. The dog remained outside for 35 minutes and was then let back into the building; neither the dog's owner nor staff were observed to clean up the patio area after the dog went to the bathroom. The maintenance supervisor stated in interview on 11/19/08 at 10:50 AM the dog's owner operated the hair salon and had been told on previous occasion not to let the dog go to the bathroom on the patio area. He added the problem was not as bad now as in the summer when resident went outside more often.	F 465	No dogs will be allowed to use the bathroom in any courtyard or resident activity area. All staff will be educated to take dogs to a area not used by residents and to clean up after the dog uses the bathroom. The Administrator, DON, and/or maintenance supervisor will conduct random audits to insure that there is no dog feces in a resident area. The result of these audits will be presented at monthly QA meetings for 3 months. Random audits will continue with results presented at quarterly QA meetings.	1/15/09
F 520 SS=E	483.75(a)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		1/15/09

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F 520	Continued From page 38 requirements of this section. 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 staff interview, resident interview, medical record review, and review of facility documents, the facility failed to ensure the quality assurance performance improvement (QAPI) program was effective in identifying and resolving problems in the facility. The findings were: 1. Review of the previous survey findings dated 1/10/08 revealed the facility was cited for not following abuse policies and procedures (F226). Refer to federal citation F226 for details related to concerns about this regulation during the 11/19/08 survey. 2. Review of the previous survey findings dated 1/10/08 revealed the facility was cited for maintenance and housekeeping (F253). Review of the OSCAR 3 report revealed maintenance and housekeeping was also cited during the 2004, 2005, and 2006 surveys. Refer to federal citation F 253 for details related to concerns about these areas during the 11/19/08 survey. 3. Review of the previous 1/10/08 survey findings revealed the facility was cited for not following professional standards (F281). Review of the OSCAR 3 report revealed the facility also was cited for not following professional standards in 2004, 2005, and 2006 surveys. Refer to federal citation F281 for details related to concerns about	F 520	F 520 483.75(o)(1') See POC for F226, F253, F281, F312, F315, F323, F329, F353, F441, F444, F465, F371, All results of random audits will be presented at monthly QA meetings. Random audits will continue with the results presented quarterly at QA meetings. Any identified problems will continue to be reported monthly until the problem is corrected.	11/5/08

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F 520	Continued From page 39 not following professional standards during the 11/19/08 survey. 4. Review of the previous 1/10/08 survey findings revealed the facility was cited for not providing adequate personal hygiene to dependant residents (F312). Review of the OSCAR 3 report revealed the facility was cited for inadequate personal hygiene during the 2005 and 2006 surveys as well. Refer to federal citation F312 for details related to concerns about this issue during the 11/19/08 survey. 5. Review of the previous 1/10/08 survey findings revealed the facility was cited for not providing incontinence care in a timely fashion (F315). Review of the OSCAR 3 report revealed the facility was cited for lack of timely incontinence care during the 2004 survey. Refer to federal citation F315 for details related to concerns about incontinence care during the 11/19/08 survey. 6. Review of the previous 1/10/08 survey findings revealed the facility was cited for not ensuring the facility was free of accident hazards (F323). Review of the OSCAR 3 report revealed the facility was cited for this regulation also during the 2006 survey. Refer to federal citation F323 for details related to concerns about safety hazards identified during the 11/19/08 survey. 7. Review of the previous 1/10/08 survey findings revealed the facility was cited for ensuring unnecessary medications were administered (F329). Review of the OSCAR 3 report revealed the facility was cited for administering unnecessary medications also during the 2004 survey. Refer to federal citation	F 520		1/15/09

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F 520	Continued From page 40 F329 for details related to concerns about unnecessary medications during the 11/19/08 survey. 8. Review of the previous 1/10/08 survey findings revealed the facility was cited for inadequate staffing (F353). Review of the OSCAR 3 report revealed the facility was also cited for inadequate staffing in 2005. Refer to federal citation F353 for details related to concerns about inadequate staffing during the 11/19/08 survey. 9. Review of the previous 1/10/08 survey findings revealed the facility was cited for not having an effective infection control program (F441). Review of the OSCAR 3 report revealed the facility was cited for not having an effective infection control program during the 2006 survey as well. Refer to federal citation F441 for details related to concerns about the infection control program during the 11/19/08 survey. 10. Review of the previous survey findings dated 1/10/08 revealed the facility was cited for not following accepted handwashing practices (F444). Review of the OSCAR 3 report revealed the facility was cited for improper handwashing practices also during the 2006 survey. Refer to federal citation F444 for details related to concerns about staff handwashing practices during the 11/19/08 survey. 11. Review of the previous survey findings dated 1/10/08 revealed the facility was cited for physical environment concerns (F465). Refer to federal citation F465 for details related to concerns about staff handwashing practices during the 11/19/08 survey.	F 520		1/15/09

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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 11/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD 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 520	Continued From page 41 12. Review of the previous survey findings dated 1/10/08 revealed the facility was cited for lack of compliance in the storage, preparation, distribution and serving of food under sanitary conditions (F371). Review of the OSCAR 3 report revealed the facility was also cited regarding this concern in 2005 and 2006. Refer to federal citation F371 for details related to concerns regarding incontinence care during the 11/19/08 survey. 13. Interview with the director of nursing and interim administrator on 11/19/08 at 8:16 AM revealed they included previous survey results in their QAPI program but stated they continue to have some of the same problems.	F 520		11/19/08