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

FEB 01 2010

PRINTED: 01/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 12/17/2009

Office of Healthcare Licensing and Surveys

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	(X5) COMPLETION DATE
F 241 SS=E	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 interview, and medical record review the facility failed to provide a dignified dining experience for 6 of 6 residents (#5, #6, #7, #12, #14, #15) who were eating at the assisted table. During 1 of 3 meal observations, 3 of the residents (#7, #12, #14) received liquefied diets without evidence of a supporting clinical rationale. In addition, the manner in which the liquid diets were provided failed to enhance each individual's self-worth, and assistance for all 6 of the residents was delayed. The findings were: A. Lack of clinical rationale for liquefied diets: 1. Review of the 10/2/09 annual Minimum Data Set (MDS) assessment showed resident #7 was totally dependent on staff for eating and had chewing and swallowing difficulties. The MDS also documented the resident received a mechanically altered, therapeutic diet. Review of physician's orders revealed thickened liquids and a speech therapy evaluation for aspiration were ordered on 5/1/09. Detailed review of the medical record failed to show a speech therapist's evaluation. However, observation during the evening meal on 12/15/09 established that the resident was receiving a full liquid diet. Observation during this meal showed residents #12 and #14 also received full liquid diets. Review of each of these resident's medical	F 241	B. 1. All CNA's will be educated related to the proper technique of assistance with meals. B. 2. All nursing staff and dietary staff will be educated related to service of meals in a timely manner. Residents #5,#6, #15, #7, #12, #14 seated at the assisted dining table will be served before the remaining residents are served to allow increased time for these residents to consume their meal in a dignified manner. All residents requiring assistance with eating will be assisted by 1 CNA/NA/licensed nurse per 2 residents. The DON/designee will insure that there is sufficient staff to allow for adequate assistance with meals. The DON/designee will conduct random weekly audits of the dining experience for residents to insure proper staffing ratios and assistance techniques. Results of these audits will be presented at monthly QA meetings.	2/1/2010

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — (X6) DATE 1/25/2010

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Refer to Page 2 for POC acceptance.

1/12/10

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F 241	Continued From page 1 record failed to show evidence a speech therapist had evaluated these residents or provided clinical rationales for their diets. On 12/21/09 at 2:27 PM, the director of nursing (DON) reiterated the facility was unable to locate any other information related to a speech therapist's evaluation and determination that full liquid diets for residents #7, #12, and #14 were the least restrictive they could safely consume. Interview with the administrator and the director of nursing on 12/17/09 at 8:45 AM revealed the evaluation was not done because there was not a therapist available. According to the administrator, the facility had been without this service since July 2009. B. Lack of dignified, timely meal assistance 1. Observation on 12/15/09 showed resident #7 was served the evening meal at 5:57 PM. No assistance was provided until 6:05 PM when CNA #1 handed the resident a banana. Assistance with the liquid diet was not provided until 6:09 PM. At 6:11 PM CNA #1 moved around the resident and picked up a liquid diet for resident #12, who was seated next to resident #7. With outstretched arms, the CNA then held a glass in each hand so that the residents could drink simultaneously from straws. At 6:15 PM CNA #1 moved around the table just to the right of resident #7 and assisted resident #14 to consume a liquid diet. At 6:19 PM the CNA again picked up glasses containing full liquid diets and held them out at arm's length so that residents #7 and #14 could drink simultaneously. During this time the CNA was talking to other staff and not watching or conversing with the residents.	F 241	Speech Therapy services have been arranged via Sinks Canyon Therapies in Lander, WY. Residents at Thermopolis Rehabilitation and Care Center who are in need of those specific services will be transported by the facility to Riverton WY hospital for consultation and resulting treatment procedures, if required. Audit of the above process will be conducted by the Nursing Home Administrator on a monthly basis. Results of these audits will be presented at monthly QA meetings.	

This POC accepted on 2/2/10 with agreed to change between R. Dee Cozens (Administrator) and Tony Mabbey

2/2/10

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F 241	Continued From page 2 During an interview on 12/17/09 at 9:35 AM, the director of nursing (DON) stated the facility normally had a CNA assist only two residents during a meal. She further stated it was not her expectation to have one CNA hold a glass in each hand while two different residents drank full liquid diets through straws. She confirmed this was an undignified way to consume a meal, but added that she was aware the practice had been ongoing since June 2009. 2. Observation of the assisted table in the main dining room on 12/15/09 from 5:15 PM to 6:30 PM (75 minutes) identified the following concerns for the six residents listed above: a. Residents waited up to 32 minutes before their meal was brought to the table (range 21-32 minutes). The assisted dining residents were the last table to be served by facility staff. b. Once food was delivered to their table, these residents waited up to an additional 23 minutes (range: 17-23 minutes) before staff actually provided functional assistance to eat. c. Only two staff members were available to assist the residents; therefore, each of the employees simultaneously assisted multiple residents. This resulted in the staff reaching across different residents to hold straws to their mouths when assisting with liquid diets. d. Nursing Assistant (NA) #7 attempted to feed resident #5 a pureed diet with a spoon while also holding a drinking straw in position for resident #12. The NA was distracted through this multi tasking effort, and, as a result resident #5, who according to the 11/23/09 quarterly MDS assessment was totally dependent on staff for eating, twice got the clothing protector in his/her mouth and was not able to eat from the spoon. The NA was unaware the resident had the	F 241		

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F 241	Continued From page 3 protector in his/her mouth and stated, "You're not eating much tonight..." e. CNA #1, one of the two staff observed at the assisted table the previous evening, stated in an interview on 12/16/09 at 11:20 AM that the DON had diverted some staff to help in other areas of the facility and, as a result, the assisted dining table had been short-staffed. She added her opinion that two staff could not adequately assist six residents. f. Interview with the DON on 12/16/09 at 2:20 PM revealed she had assigned a new aide to one of the units and, therefore, the assisted table was "short" at the start of the meal. The DON further stated she was not aware of the problem with the assisted table because staff had not let her know.	F 241	
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS 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 interviews, medical record review, review of quality control logs and policies and procedures, the facility failed to ensure staff maintained professional standards of practice related to disinfecting the glucometer, medication administration, and completion of nursing procedures. The findings were: A. Related to disinfecting the glucometer: 1. Review of sixty days (10/15/09 through 12/15/09) of quality control data for a Quintet blood glucose monitoring system ("glucometer") found on medication cart #1 showed six instances in which control results were outside the	F 281	F281 483.20(k)(3)(i) A. Licensed nurses will be educated regarding proper technique for testing glucometers and recording readings for same. Licensed nurse #5 and all licensed nurses will also be educated regarding proper technique of documentation and action/actions taken if the control results are outside the manufacturer's published range for acceptable values. Licensed nurses will be educated regarding manufactures guidelines to remedy or correct out of range conditions of glucometer testing results. The DON/designee will insure that there is proper glucometer testing materials available to nursing staff at all times. The DON/designee will also have a back-up glucometer available for use if the glucometer test result is outside the range of acceptable values and using the manufacturers corrective actions is not successful in producing an acceptable value. 2/1/2010

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F 281	Continued From page 4 manufacturer's published range for acceptable values. In no instance did staff annotate an awareness of the unacceptable results nor were corrective actions documented to show if the test equipment was determined to be acceptable for resident testing. The out-of-range conditions for the glucometer were: a. 11/09/09, Level 1 result was 110 mg/dl with an acceptable range 74-100 mg/dl b. 11/12/09, Level 1 result was 112 mg/dl with an acceptable range 74-100 mg/dl c. 12/15/09, Level 1 result was 109 mg/dl with an acceptable range 71-97 mg/dl d. 10/31/09, Level 2 result was 202 mg/dl with an acceptable range 228-308 mg/dl e. 11/03/09, Level 2 result was 215 mg/dl with an acceptable range 228-308 mg/dl f. 11/08/09, Level 2 result was 215 mg/dl with an acceptable range 224-302 mg/dl In addition to these unacceptable control results, there were no quality control results recorded for the Level 2 control from 11/15/09 through 11/24/09 (10 days). The missing results were annotated as "no solution available." 2. Interview with licensed practical nurse (LPN) #5 on 12/15/09 at 9:45 AM revealed the facility's policy required staff to test 2 levels of quality control material on each day of resident testing and each control value had to be within the acceptable range of values established by the manufacturer. The LPN further stated staff were required to circle out-of-range values and document corrective actions (i.e., repeat, clean, calibrate, contact technical assistance) on the glucometer logsheet. She acknowledged the cited values were not treated in accordance with facility policy. She further stated she was not aware the facility had been out of Level 2 control material in	F 281	B.2.1. Resident #7 was evaluated and exhibited no s/s of adverse reactions as a result of receiving the Aricept at the incorrect time. A physician order has been obtained to administer the medication at 1700. 2. The physician has been notified regarding the Calcium order for resident #16 and an order has been requested for clarification of the Calcium/Vit D dosage. Resident #16 has been receiving the current ordered dosage of Calcium/Vitamin D. Licensed nursing staff will be educated regarding the "6 Rights of Medication Administration".	

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F 281	Continued From page 5 November. B. Related to medication administration: 1. Observation on 12/14/09 showed licensed practical nurse (LPN) #2 prepared and administered Aricept 5 milligrams (mg) to resident #7 at 5:56 PM. Reconciliation of the medication with physician orders showed it was specifically ordered to be administered at bedtime. The LPN provided no explanation for not administering Aricept at bedtime as ordered. According to the 2008 Seventh Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, if an order "is questionable for any reason, the physician must be notified for clarification." 2. Observation on 12/14/09 showed LPN #2 prepared and administered CalCarb 600 mg with vitamin D at 6 PM for resident #16. When questioned about the amount of vitamin D, the LPN reviewed the label and confirmed the dose was not indicated. She stated it was "what the pharmacy sends" for administration. Reconciliation of the medication showed the physician ordered Calcium 500 mg with vitamin D 400 mg. On 12/15/09 at 8:30 AM the director of nursing (DON) removed the pharmacy's over-label from the empty container and revealed the manufacturer's label specified 400 mg of vitamin D. She confirmed staff should have clarified the dosage. Review of the 2008 Seventh Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin showed "safe administration" of medications "requires adherence to the 'Six Rights' each time a medication is given." One of the "Six Rights" included verification of the right dose.	F 281	Audits of the above process Will be conducted by the DON /designee on a Monthly basis and presented At the monthly QA meeting.	

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F 281	Continued From page 6 C. Related to incomplete nursing procedures: 1. Review of the facility's policy and procedure entitled "Neurological Evaluation" last revised April 2005 showed "neurological evaluations will be initiated and continued for 72 hours" for any resident having a fall resulting in a suspected or known head injury. Further review showed the facility's "Neurological Check Flow Sheet" required the evaluations be completed every 15 minutes for the first hour, every 30 minutes for the second hour, every hour for the next two hours, every 4 hours for the remainder of the first 24 hours, then every 8 hours for the remainder of the 72 hour period. Failure to complete neurological (neuro) checks per the policy and procedure was identified in the following instances: a. According to nursing documentation, resident #7 was found on the floor on 9/26/09. As this was an unwitnessed incident and whether the resident hit his/her head was unknown, neurological checks were initiated. However, review of the flow sheet showed no evidence the checks were completed per the facility's time line. In addition, the required elements of pupil response, hand grasps, movement of extremities, response to pain, and vital signs were not always completed each time a check was conducted. b. According to the medical record, resident #15 fell on 11/18/09. Further review showed neurological checks were started at 6:30 AM, but, according to the documentation, the checks were not performed properly. The documentation showed both pupils were equal and reactive to light, but both were also documented as non-responsive. Movement of extremities was not documented at all, and the vital signs were not always completed. Finally, the facility's required time line was not followed.	F 281	C.1.a. Resident #7 has been re-evaluated and shows no change from baseline evaluations prior to 092609. b. Resident #15 has been re-evaluated and shows no change from baseline evaluations prior to 111809. c. Resident #36 has been re-evaluated and shown no change from baseline evaluations prior to 092209. All nursing staff will be educated related to the necessity of initiating and completing neurological evaluations after resident fall resulting in a suspected or known head injury.	

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F 281	Continued From page 7 c. Review of the medical record showed resident #36 had an unwitnessed fall on 9/22/09 at 3:20 PM. Neurological checks were initiated as it was unknown whether the resident hit his/her head, but they were not completed per the facility's time line. Nor were pupil response, level of consciousness, motor functions, response to pain, or vital signs always completed. Interview with the DON on 12/16/09 at 1:55 PM revealed the policy and supporting forms were current. She stated all criteria for the neurological checks should have been completed, or staff should have indicated the reason they were not. 2. At 4:50 PM on 12/16/09 the DON stated she had no record of competencies for licensed staff. During an interview on 12/17/09 at 8 AM, the administrator confirmed the facility did not have competency checks for licensed staff.	F 281	F312 483.25(a)(3) CNA #3 received individual instruction related to perineal care. All nursing staff will receive education related to perineal care. The DON/designee will perform weekly random audits observing the performance of perineal care. Failure of a nursing staff personnel to complete perineal care appropriately will result in further individual instruction and supervision Resident # 29 was assessed For skin breakdown r/t Improper perineal care After an episode of bladder Incontinence and no skin Breakdown was noted. The results of these audits will be presented at monthly QA meetings.	2/1/2010
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 and staff interview, the facility failed to ensure staff provided appropriate perineal care for 1 of 3 residents (#29) who had been incontinent and required staff assistance with perineal care. The findings were: Observation on 12/15/09 at 7:55 AM showed non-sample resident #29 had been incontinent of urine. When certified nursing assistant (CNA) #3	F 312		

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F 312	Continued From page 8 provided perineal care, she failed to cleanse the anterior groin and perineum. Interview with the CNA immediately after the observation confirmed the resident had been incontinent of urine. The CNA verified that she did not complete perineal care correctly. She stated she was taught to cleanse the groin and perineum when doing perineal care.	F 312		
F 323 SS=D	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, staff and resident interview, and medical record review, the facility failed to have a speech therapist evaluate swallowing problems as ordered to minimize choking hazards for 1 of 5 sample residents (#10). The findings were: Observation on 12/14/09 at 5:45 PM and 12/16/09 at 5:18 PM revealed resident #10 was independent when eating, except for set-up assistance. Review of a communication form to the resident's physician, dated 11/29/09, revealed the resident was having "daily episodes of choking at meal times." The physician responded with an order, dated 12/1/09, for a speech therapist to evaluate and treat. However, medical record review showed no evaluation had been done by a speech therapist. Interview with the	F 323	F323 483.25(h) Speech Therapy services have been Arranged for resident # 10 via Sinks Canyon Therapies in Lander, Wy. Resident #10 will be transported By the facility to Riverton, Wy. Hospital for consultation and Resulting treatment procedures If required. Audit of the above process will be conducted by the Nursing Home Administrator on a monthly basis. Results of these audits will be presented at monthly QA meetings.	2/1/2010

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F 323	Continued From page 9 resident on 12/16/09 at 1:30 PM revealed s/he sometimes choked on food. In addition, s/he confirmed a swallowing evaluation had not been done. Interview with the administrator and the director of nursing on 12/17/09 at 8:45 AM revealed the evaluation was not done because there was not a therapist available. According to the administrator, the facility had been without this service since July 2009.	F 323		
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 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:	F 329	**F329 483.25(1) UNNECESSARY DRUGS** Feb 1, 2010 1. Resident #36 – Corrective Action On 12/14/2009 a request for reduction of the dosage of the Celexa from 20 mg per day to 10 mg per day was sent to the primary physician. The physician signed the order for the reduction of the Celexa on 12/15/2009. The reduction of this medication has been accomplished. 2. Resident #15 – Corrective Action On 12/14/2009 a request for reduction of the dosage of Remeron from 15 mg Q/HS to 7.5 mg Q/HS was sent to the primary physician. The physician signed the order for the reduction of the Remeron on 12/15/2009. The reduction of this medication has been accomplished.	

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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 12/17/2009

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

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F 329	Continued From page 10 Based on medical record review, staff interview, and interview with the consulting pharmacist, the facility failed to ensure the medication regimens for 2 of 13 sample residents (#15, #36) were free of unnecessary medications. The findings were: 1. According to the physician's orders and medication administration records (MARs), resident #36 had received the antidepressants Celexa 20 milligrams (mg) since 9/11/08 and Remeron 15 mg since 2/16/09. Review of the Geriatric Depression Scale (GDS) dated 11/11/09 showed the resident exhibited no indicators of depression. Review of the medical record showed no evidence that reducing the dosages of either medication had been considered prior to the survey, nor was there evidence the physician had provided a rationale for continuing both medications at the same dose. On 12/16/09 at 1:55 PM, the director of nursing (DON) stated she was unable to find any documentation related to the risks of continuing the medications at the same dose versus the benefits derived from their use. She further stated she was unaware of the need for a physician's rationale. On 12/16/09 at 4:45 PM, the social services director (SSD) verified she kept the psychotropic medication review information. She stated she was unable to find a physician's rationale for continued use of the antidepressants, and she confirmed the GDS was correct. Interview with the consulting pharmacist on 12/21/09 at 10:40 AM confirmed there was no documentation from the physician. 2. Review of the physician's orders and MARs showed resident #15 had received Remeron 15 mg daily since 1/2/09. Medical record review showed no evidence a reduction in the dosage of this antidepressant had been considered. Further	F 329	Residents #36 and #15 will be monitored for signs and symptoms of increased depression or behaviors. Any adverse symptoms will be referred to the Psychoactive Committee for further consideration with appropriate notification to the primary physician. Plan of Action to prevent re-occurrence: 1. Implementation of usage of Psychoactive Medication Quarterly Evaluation forms. These forms will allow the Psychoactive Committee, which will include the Director of Nursing/designee, the Minimum Data Sets Coordinator, the Director of Social Services, and Pharmacy Consultant , to review each Resident's drug regimen, , psychoactive drug use, evidence of side effects, if any , diagnoses, Geriatric Depression Scale results, non-pharmaceutical interventions attempted, and physician's response to the request for	

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PRINTED: 01/05/2010
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 11 review showed no evidence the physician had evaluated the risks versus the benefits of continued use of the medication at the same dose. On 12/17/09 at 9 AM, the SSD confirmed the facility lacked a physician's rationale for continuing the medication or for not attempting a dose reduction. Interview with the consulting pharmacist on 12/21/09 at 10:40 AM confirmed there was no documentation from the physician.	F 329	reduction/discontinuance in psychoactive medications. The Director of Social Services will implement and maintain the quarterly review forms in the Psychoactive Medication Review book. When the review is completed and all documentation of the drug review is received, a copy of that form will be placed into the Resident's Medical Record and a copy maintained in the Psychoactive Medical Review book. 2. The Director of Social Services will maintain a separate record of all residents receiving psychoactive medications. That record will be updated each month prior to the Psychoactive Review Committee meeting. The Pharmacy Consultant will be provided with a copy of that record in order to assist with identification of those individuals who are due for quarterly review of their medications. The Psychoactive Medications Review Committee will receive training on the regulations governing the use and monitoring of psychoactive medications for individuals in a long term care setting.	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356		

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F 356	Continued From page 12 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the nursing schedule, the facility failed to post the nurse staffing data as required. The findings were: Review of the nursing schedule requested during the entrance conference on 12/14/09 at 3:03 PM showed a daily list of staff who would be working each shift for the coming week. On 12/16/09 at 2 PM, observation of the posted staffing information showed copies of the same information were hanging in the entrance foyer. Interview with the director of nursing (DON) on 12/17/09 at 7:45 AM revealed she posted the information for a week at a time. The DON stated she was in the facility seven days a week, and, if she remembered to do so, made changes as they occurred. After business hours the charge nurse was to make the changes. However, observation at the time of the interview showed the posted information was still for the previous day. The DON further stated she did not have eighteen months of information as her copies only went back to January 2009. Finally, the DON stated she was unaware of the specific information required by the regulation for posting the staffing data.	F 356	Training on behavioral interventions and tracking behaviors and interventions prior to administration of psychoactive medications will be completed for direct care staff. 3. Audit of the above process will be conducted by the Nursing Home Administrator on a monthly basis. Results of these audits will be presented at monthly QA meetings. F356 483.30(e) A new form for nurse staffing data has been implemented. It is posted daily at the beginning of each shift with the hours scheduled for each RN, LPN, CNA, Bath Aide, and Restorative Aide. This form also contains the name of the facility, the date and the resident census. This form will be posted at the start of the each shift. The DON/designee will complete the form with the actual hours worked on the	Feb 1, 2010
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		

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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of in-service information, the facility failed to follow safe practices for cooling potentially hazardous food. The findings were: Observation on 12/14/09 at 3:30 PM revealed a large pork roast (approximately 20 pounds) cooling in the walk-in refrigerator. The roast was in the pan in which it was cooked. Additionally, it was covered tightly with foil, creating a situation that would further delay the cooling process. Interview with the dietary manager at the time of the observation revealed the roast was being cooled for the next day's lunch. She stated the roast had been put into the walk-in refrigerator at 1 PM, and she did not know the temperature of the roast at that time. Observation revealed that when the temperature was taken by the dietary manager at 3:30 PM, the roast was 108 degrees Fahrenheit (F). Interview with the dietary manager at that time revealed the facility did not keep track of time or temperatures when cooling foods. At 7 PM (six hours after the roast had been put into the cooler) the evening cook again took the temperature of the roast and discovered it was 64 degrees F. Interview with the cook regarding the facility's cooling process verified the facility did not have time controls for cooling foods or monitor temperatures during the cooling process. Interview with the registered dietitian (RD) on 12/17/09 at 12:10 PM revealed he was surprised	F 371	next business day. The posted daily schedule will be updated with any necessary changes as needed by the DON/designee. The DON will insure that all schedule records are kept in an orderly fashion and will be retained for a period of at least 18 months. The posted daily schedule records will be monitored for accuracy and completion on a monthly basis by the DON/designee. The results of these audits will be presented at monthly QA meetings.	

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PRINTED: 01/06/2010
FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 14 at the inappropriate procedure used in cooling the roast as he had provided in-service education on this topic in September 2009. Review of the in-service information confirmed the topic was covered as stated by the RD. 1. According to Food Code 2005, U.S. Public Health Service 3-501.14 Cooling. "(A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled: (1) Within 2 hours from 57°C (135°F) to 21°C (70°F); and (2) Within a total of 6 hours from 57°C (135°F) to 5°C (41°F) or less..." 2. 3-501.15 Cooling Methods. "(A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under § 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods."	F 371	F371 483.35(i) All dietary staff has been inserviced regarding the proper time/temperature control for safety food (Food Code 2005, US Public Health Service 3-501.14 Cooling. A policy has been developed and implemented to meet this federal guideline. Random audits of the cooling temperatures of cooked food will be conducted weekly for 4 weeks, monthly for 3 months and quarterly thereafter to assure continued corrective functioning. Results of these audits will be presented at the QA meeting as they are completed.	Feb 1, 2010
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a 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	F 441		

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F 441	Continued From page 15 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 staff interview and review of infection control records, the facility failed to maintain an accurate and complete surveillance program for 4 (May, June, July, and September 2009) of 8 months reviewed. The facility further failed to routinely conduct monitoring activities to ensure staff practiced appropriate hand hygiene. The findings were: 1. Review of the facility's infection control program on 12/16/09 included an evaluation of surveillance records and staff interviews. An interview with the director of nursing (DON) and infection control nurse (ICN) on 12/16/09 at 3:30 PM showed the DON misunderstood the definition of nosocomial (i.e., healthcare associated) infections. As a result, she misidentified the status of resident infections for 4 (May, June, July, and September 2009) of 8 months. According to the Centers for Disease Control and Prevention (CDC): "The term healthcare-associated infection (HAI) is used to refer to infections associated with healthcare delivery in any setting (e.g., hospitals, long-term care facilities, ambulatory settings, home care)." The facility's infection control surveillance data showed 9 of 12 infections (75%) in May, 8 of 13 infections (62%) in June, and 7 of 10 infections (70%) in July were coded as being acquired	F 441	F441 483.65(a) 1. The DON and Infection Control Nurse have received education related to nosocomial infections. The Infection Control Log for resident #51 has been corrected to reflect the presence of a nosocomial infection. 2. The facility has a policy defining the relevant criteria for tracking resident infections containing necessary information to be collected to complete actions or conditions to be monitored. The tracking log has been modified to reflect the antibiotic ordered and any noted side effects of the drug. The DON/designee will perform monthly audits of the infection control records to insure compliance with policy.	Feb 1, 2010

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F 441	Continued From page 16 outside the healthcare environment. Further, supplemental resident #51 was listed as having both nosocomial and non-nosocomial infections in the month of September 2009 with no explanation for the differences in the associations of the infections. The DON stated in her 12/16/09 interview that she should have recorded the infections cited in May, June, July, and September 2009 as healthcare associated. 2. During the 12/16/09 interview, both the ICN and DON acknowledged the facility lacked a written surveillance plan to guide the data-collection process, define relevant criteria for tracking resident infections, and provide a list of actions or conditions to be monitored. For example, the ICN stated she was not presently monitoring antibiotic usage among residents, instead she tracked culture results to determine the infection status of residents. She acknowledged some residents received antibiotic therapy without culture results and these residents would not be monitored under the present surveillance method. 3. Per the 12/16/09 interview with the ICN, it was discovered the facility failed to develop a systematic monitoring program to ensure staff complied with appropriate hand hygiene standards. The ICN provided documentation to show hand washing was tracked as part of the assessment process for feeding residents in the dinning room. However, she acknowledged there were no other systems in place to observe and evaluate hand hygiene among staff providing cares, assisting residents with activities of daily living, or among non-nursing employees.	F 441	3. All staff will be educated related to the correct procedure for hand washing to include demonstration and return demonstration. Random audits of all staff will be conducted to monitor for proper hand washing. The results of all audits will be presented at monthly QA meetings to insure compliance.	
F 500	483.75(h) USE OF OUTSIDE RESOURCES	F 500		

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F 500 SS=D	Continued From page 17 If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure speech therapy services were available to meet the needs of 1 of 1 sample residents (#10) who had physician orders for speech therapy. The findings were: Medical record review showed a physician's order dated 12/1/09 for speech therapy to evaluate and treat resident #10 related to daily episodes of choking during meals. Interview with the administrator and the director of nursing on 12/17/09 at 8:45 AM revealed the order was not carried out because the facility did not have a speech therapist available to perform the service. The administrator stated the facility had been without a speech therapist since July 2009. Refer	F 500	F500 483.75(h) Speech Therapy services have been Arranged for resident # 10 via Sinks Canyon Therapies in Lander, Wy. Resident #10 will be transported By the facility to Riverton, Wy. Hospital for consultation and Resulting treatment procedures If required. An occupational therapy consult has been requested from the physician for evaluation and recommendation regarding texture and feeding assistance required for this resident to insure safety during meals. Licensed nurses will monitor and document resident tolerance to texture of foods offered. All orders for speech therapy referral s will be handled in the above described manner. Audit of the above process Will be conducted by the Nursing Home Administrator On a monthly basis. Results of These audits will be presented At monthly QA meetings.	2/1/2010

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F 500	Continued From page 18 to F323 for details regarding the resident's current status.	F 500		
F 503 SS=E	483.75(j)(1)(i-iv) LABORATORY SERVICES If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the manufacturer's instructions, and the requirements found in 42 CFR Part 493 (Clinical Laboratory Improvement Amendment: Requirements for Laboratories), the facility failed to prevent the use of 1 of 1 bottles of expired urine test strips and further failed to maintain a glucose testing device ("glucometer") as specified by the device's manufacturer. The findings were:	F 503	F503 483.75(j)(1)(i-iv) 1. The expired container of urine test strips has been discarded. All laboratory supplies and medications will be reviewed on a monthly basis. Expired medications and laboratory supplies will be discarded. 2. Licensed nurses will be educated regarding the proper technique for cleaning glucometers. Glucometers will be cleaned after each patient use. All medication carts and cupboards will be monitored on a monthly basis to insure that all expired laboratory supplies and medications have been properly discarded. The results of these audits will be presented at monthly QA meetings. Random audits will be completed to observe the proper cleaning of glucometers. The results of these audits will be presented at monthly QA meetings.	Feb 1, 2010

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F 503	Continued From page 19 1. Observation on 12/15/09 at 10:40 AM showed a bottle of urine test strips (Chemstrip 10 + SG) labeled with a quantity of 100 strips and an expiration date of 2009-11. Thirty one test strips remained in the container. At 11:05 AM that day, licensed practical nurse (LPN) #4 was observed to retrieve the container of expired test strips from the counter and place it in a locked cupboard. Interview with the LPN on 12/15/09 at 11:07 AM revealed she was unaware the urine test strips were expired; she stated she was putting them back into the locked laboratory storage cabinet until they were used again. When shown the expiration date on the label, she acknowledged the product was expired, a fact she had previously overlooked. 2. Observation on 12/14/09 at 5 PM showed staff used an alcohol pad to clean the exterior surface of a glucometer (Quintet Blood Glucose Monitoring System, PSS World Medical, Inc.). Interview with LPN #2 revealed staff routinely cleaned the glucometer with alcohol. a. Review of the manufacturer's instructions for cleaning the glucometer (User's Manual, revision 03/08, page 56) showed the approved method for cleaning the exterior surface required the use of "...a damp cloth and mild soap/detergent. Keep the test strip port and Smart Code Key base from getting wet." There was no documentation in the literature provided with the glucometer to indicate cleaning with alcohol was an acceptable practice. b. The staff in-service training coordinator and infection control nurse, LPN #5, stated in interview on 11/15/09 at 2:15 PM that staff used alcohol pads to disinfect the glucometer between residents. When asked by the surveyor, she acknowledged the facility had not contacted the	F 503		

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F 503	Continued From page 20 manufacturer to determine if alcohol was an acceptable cleaning solvent in lieu of the "...damp cloth and mild soap..." described in the user's manual. c. The LPN reported on 11/15/09 at 2:40 PM that her telephone call to the manufacturer's representative revealed the facility was to adhere strictly to the instructions accompanying the instrument and that cleaning with alcohol was unacceptable.	F 503		
F 520 SS=E	483.75(o)(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 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	F 520	F520 483.75(o)(1) Each monthly QA meeting will include results of all audits detailed in above F-Tags. Any audits not at 100% compliance will be referred to a multidisciplinary team for further review and action. The multidisciplinary team will evaluate the problem, determine the underlying cause of the problem, provide a plan to correct the problem, assist with implementation of the corrective action and continue to monitor the problem for compliance. This process will continue until there are acceptable levels of compliance for each identified problem or area of deficiency.	Feb 1, 2010

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PRINTED: 01/05/2010
FORM APPROVED
OMB NO. 0938-0391

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

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 12/17/2009

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

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F 520	Continued From page 21 by: Based on observation, staff interview, review of the quality assurance performance improvement (QAPI) program and minutes, medical record review, and review of quality control logs, inservice education, and policies and procedures, the facility failed to ensure the program was effective in identifying problems and implementing actions to resolve those problems. The failure specifically affected 1 supplemental resident and 3 of 13 sample residents, whose care was deficient in areas cited during previous surveys. In addition, the facility failed to identify and implement action plans to correct other issues that were identified by the survey team as ongoing or systemic. The findings were: 1. During an interview on 12/17/09 at 8:01 AM, the administrator revealed the facility's QAPI program was not a multi-level, facility-wide process. For example, the program did not identify the root cause of problems or potential problems, or develop, implement, and monitor solutions to resolve those problems. The administrator stated the facility had no formal, overarching plan for the QAPI program. He further stated the QAPI committee met monthly with staff briefings Monday through Friday to troubleshoot specific problems, but they did not determine the underlying cause of those problems. Review of the QAPI program and committee minutes confirmed the facility lacked a plan which proactively identified concerns, developed criteria for monitoring, implemented action plans, and developed benchmarks for tracking the level of success of the action plans. In addition, the facility had not implemented a method to review and revise action plans that were ineffective.	F 520	Additionally, each month the QA committee will assign the same process to any and all areas of concern identified or presented at the QA meeting. Problems identified or presented during the normal AM briefing will be referred to the appropriate department head for audit/monitoring. The results of these audits will then be presented at the monthly QA meetings with the above described action to be implemented and followed.	

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F 520	Continued From page 22 2. During the survey, ongoing deficient practice was identified in the following care areas: a. Refer to F312 for details related to failure to adequately assist a dependent resident with incontinence care. Previous deficiencies at F312 were written during the last four surveys. b. Refer to F323 for information regarding the facility's failure to provide adequate evaluation and assistance to prevent choking. Previous deficiencies were written at F323 during the last three surveys. c. Refer to F329, also written during the last two surveys, for details related to failure to ensure residents' medication regimens were free of unnecessary drugs. 3. The program failed to identify and resolve systemic dietary issues. Refer to F371, also written during three previous surveys, for further information. 4. Due to failure to correct previously cited deficiencies at F281 (last four surveys), F441 (last three surveys), and F520 (last full survey and revisit survey), deficiencies in these areas were also written on this survey. Refer to these specific F tags for details of current non-compliance.	F 520		

2/2/10