POC accepted 7/7/09 Janice Cox, OMIC

RECEIVED
Wyoming Dept of Health
JUL 01 2009

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

PRINTED: 06/24/2009
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 ~~Office of Healthcare~~ B. WING Licensing and Surveys	C 06/10/2009

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 314 SS=H	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to have an effective system in place to prevent, identify, monitor, and provide treatment related to pressure sores. This failure resulted in avoidable harm for three (#1, #4, #5) of eight sample residents who were assessed at risk for pressure sores. The findings were: 1. Review of the admission face sheet for resident #5 showed s/he was admitted to the nursing facility on 1/9/09. Review of the 1/9/09 nursing admission assessment showed the resident had no pressure ulcers and his/her risk for skin breakdown was moderate. The following concerns were identified: a. Review of the 2/15/09 timed at 6 AM nursing notes revealed there was an open area on the coccyx which measured 5 centimeter (cm) by 5 cm. Review of the 2/15/09 timed at 9:45 AM nursing notes showed the coccyx was blistered and when the DuoDerm dressing was removed, the pressure sore was oozing fluid and measurements had increased in size from 5 cm by 5 cm to 5.5 cm by 7 cm. Review of the 3/17/09	F 314	Preparation and execution of this Response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 7317A of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Admin	7/1/2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. Changes made per phone call with Dee Cozzens, Admin on 7/7/09 @ 1415; Janice Cox, OMIC

7/8/09

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

PRINTED: 06/24/2009
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 06/10/2009

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 314	Continued From page 1 physician fax telephone order revealed the coccyx pressure sore had worsened to a stage IV wound with one-half inch tunneling around the edges and a wound vac was required. Review of the 3/20/09 physician visit notes revealed the coccyx wound was "toxic" and had worsened from stage II to stage IV. On 3/20/009, according to the nursing notes, the resident was transferred to the emergency room for debridement of the coccyx wound. According to a second 3/20/09 physician's telephone order the resident required admission to the hospital for debridement of the wound. b. Review of the February 2009 medication administration record revealed there were physician orders dated 2/23/09 for Mepiplex and dressing changes as needed to the sacral area and heel. Review of the 3/1/09, untimed, nursing notes showed staff was unable to locate Mepiplex so they used another dressing on the coccyx instead. In addition, review of the 2/28/09 nursing notes timed at 7 AM showed the heel wound dressing was saturated with drainage and needed to be changed. Further review of the notes showed the dressing on the heel was changed but "unable to find what [dressing] was on it so put a Aquacue? Abd [abdominal] pad" and covered it with a Tegaderm dressing. c. Review of the 1/20/09 care plan revealed an intervention for pressure relieving devices to the bed. However, review of the 3/17/09, untimed, nursing notes revealed an air mattress was placed in the room for a stage II, stage III, and stage IV wound on the coccyx 31 days after the wound was identified and 56 days after it was written as a preventive intervention on the care plan. During an interview with licensed practical nurse (LPN) #1, who helped care for this resident, on 6/10/09 at 2:46 PM, she stated she was unsure why the air mattress was not placed on	F 314	July 3, 2009 F314 483.25(c) PRESSURE SORES 1. Resident #5 has been discharged. 2. Resident #4 has been discharged. 3. Resident #1 currently has a decubitus ulcer on his bilateral heels. They are healing. The right heel measures 1.5 X2 cm. The left heel measures 1.5 X 2.2 cm. They are being treated per our wound protocol with supporting orders from the physician. The nursing staff has been inserviced related to wound prevention, wound treatment, wound assessment and staging, measurement and accurate documentation. All residents have had a skin assessment. There is currently only one resident with a pressure sore (#1).	

7/8/09 jc

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

PRINTED: 06/24/2009
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 06/10/2009

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 314	Continued From page 2 the resident's bed on 1/20/09 when pressure sores were first identified as a potential problem and added as an intervention on the resident's care plan. d. In addition to the above noted pressure sore on the coccyx and heel, the resident also developed the following pressure sores after admission to the facility: Review of the 2/15/09 nursing notes timed at 8 AM revealed there were four reddened areas on the left foot/ankle. Review of the 2/15/09 nursing notes timed at 9:45 AM revealed there was a 6 cm by 8 cm blister on the right heel and a 1 cm by 2 cm sore on the right side of the resident's mid back area. There were also two sores on the left foot with the front sore measuring 1 cm by 2 cm and the middle sore measuring 1 cm by 1 cm, the heel sore was 1.2 cm by 2.5 cm and the ankle was 1 cm by 1.5 cm. Review of the 2/16/09 nursing notes timed at 8:30 AM revealed there was a new reddened area approximately 0.25 cm on the right second toe and a 0.5 cm reddened area on top of the third right toe. e. Review of the death certificate issued on 5/15/09 showed severe decubitus ulcers was a significant condition for this resident and were noted to be an underlying cause of death. 2. Review of the 1/9/09 admission physician's orders for resident #4 revealed s/he had a diagnosis of a fractured right femur. Review of the 1/9/09 admission nursing assessment revealed the resident had no pressure sores upon admission. Further review of this document revealed the resident was at moderate risk for skin breakdown. Review of the 1/27/09 nursing notes for the 6 PM to 6 AM shift revealed the physician removed the resident's long leg cast and applied a posterior splint, which was held in	F 314	A wound and treatment nurse has been hired. This nurse is responsible for daily assessment of all wounds. This nurse will also perform weekly skin rounds on all residents. Treatment for wounds will be determined by collaboration with the resident's physician, the medical director and our wound protocols. Physician orders will be obtained prior to beginning wound treatment unless the physician has accepted our standardized wound protocol as the preferred treatment for identified wounds. Weekly skin rounds will be documented in the resident chart and on a log kept by the wound and treatment nurse. Daily wound assessment will be kept in the treatment record until the wound is healed then will be placed in Telephone orders will be used to notify physicians timely of pressure sores. jc	

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

7/31/09 je

PRINTED: 06/24/2009
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 06/10/2009

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 314	Continued From page 3 place with an ace bandage. Review of the 1/27/09 physician orders documented that the splint could be removed for bathing and hygiene. The following concerns were identified: a. Review of the notes from a 2/4/09 physician's visit revealed there was a sore on the top of the resident's right foot. Review of the 2/10/09 nursing notes for the 6 PM to 6 AM shift revealed there was a dry open area on top of the shin of the right leg, a dry open area on top of the right foot, a dry open area on the lateral right ankle, and a one-half dollar size ulcer with black eschar on the right heel. Review of the day shift nursing notes revealed the physician was not notified of the open areas until 2/14/09 (four days after the aforementioned pressure sores, were identified). Review of the 2/14/09 fax telephone orders timed at 2 PM revealed a nursing note advising the physician that the posterior splint would not stay in position and was causing pressure areas on the heel and ankle. This fax also noted the physician ordered sheepskin for the right heel, a long leg knee immobilizer, which could be removed for bathing and hygiene (to replace the posterior splint to the right leg), and a physical therapy (PT) consultation regarding the foot wounds. Review of the PT assessment performed on 2/18/09 (four days after it was ordered and eight days after the sores were identified), revealed there were four wounds on the right foot and a fifth ulcer on the right heel. The foot wounds were described as follows: wound #1 measured 2.4 cm by 1.6 cm, wound #2 measured 1.9 cm by 1.1 cm, wound #3 measured 1 cm in diameter (anterior to lateral malleolus), and wound #4 measured 0.8 cm in diameter posterior to the lateral malleolus. The pressure ulcer on the heel measured 4.1 cm by 3.5 cm. Review of the 2/19/09 physician's record of visit	F 314	the resident chart. The physician will be kept informed of the progress of the wound on a weekly summary note. A copy of this note will be placed in the resident chart. The MDS Coordinator will complete all admissions. All skin assessments will be completed within 24 hours of admission. These assessments will be placed in the resident chart with a copy to the wound and treatment nurse for follow up as needed and as a baseline assessment for weekly skin rounds. All ~~skin assessments~~ bath sheets completed by the CNAs or bath aides will be directed to the wound and treatment nurse. She in turn will review the assessment and determine if there are any	

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

7/8/09 JC

PRINTED: 06/24/2009
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 06/10/2009

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 314	Continued From page 4 notes revealed the posterior splint was removed due to skin breakdown. b. Review of the 3/12/09, untimed, nursing notes revealed there was a newly identified unopened blister noted to the back side of the right knee. Review of the 3/12/09 physician's progress note revealed there was a new pressure sore on the lateral distal femur area, described as an open blister by the nursing staff: "This new pressure sore is probably due to improper placement of the knee immobilizer. There is also a new pressure sore under the most proximal strap of the right drop-foot splint, which will have to be monitored better to prevent a full thickness decubitus." c. Review of the 3/25/09, untimed, nursing notes revealed there was scant weeping from the area near the back of the right knee and the area was black. Review of the 3/26/09 physician's visit notes revealed there were two new pressure sores: there was fresh bleeding at the proximal heel eschar site that was noted to be "(painful)" and there was a 5 cm by 10 cm eschar mid-leg (posterior/lateral) in association with the proximal lateral margin shell of the drop-foot splint. d. Interview with LPN #1 on 6/10/09 at 2:45 PM revealed she was unsure why the physician was not notified until four days after the initial sores were identified. Interview on 6/19/09 at 2 PM with RN #1 revealed this resident was frequently non-compliant with care Review of the 1/23/09 care plan identified altered mental status, mood, and behaviors as a potential problems. However, there were no interventions identified regarding how to provide appropriate care and monitoring of pressure sores during the resident's difficult behaviors. 3. Review of the 10/6/08 annual Minimum Data	F 314	areas of concern. Any wounds identified will then be assessed by the wound nurse. The wound nurse will then determine what, if any, treatment is indicated and seek appropriate orders. All licensed nursing staff will be inserviced related to wound assessment, treatment by the wound and treatment nurse to insure continuity of care by July 10th 3, 2009. The DON/designee, the MDS coordinator/Medicare nurse, the wound /treatment nurse and the dietary manager will meet weekly to evaluate skin issues and treatments. All current wound reports will be presented each day at morning briefing.	

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

7/8/09

PRINTED: 06/24/2009
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 06/10/2009

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 314	Continued From page 5 Set (MDS) assessment for resident #1 revealed s/he was totally dependent on staff for all cares. Review of the medical record face sheet showed the resident was a patient in the hospital from 4/12/09 through 4/17/09, and, according to the 4/17/09 re-admission nursing assessment, the resident had one pressure ulcer on the left heel, one on the right heel, and one on the coccyx. The following concerns were identified: a. Review of the 4/17/09 admission nursing assessment showed the comprehensive pressure sore risk assessment was incomplete, the wounds were not staged or measured, and no specific treatments were identified. Review of the 4/17/09 admission physician's orders revealed there were no orders to address pressure sores, and pressure sores were not identified as a diagnosis. The nursing notes documented that the pressure sores were not again addressed until 4/22/09 (five days later) and were still not staged or measured. In addition, the coccyx redness noted on the 4/17/09 re-admission nursing assessment was not addressed again. b. Review of the nursing fax communication and subsequent physician orders showed the physician had not been notified about the pressure sores until 4/27/09 (ten days after the sores were identified). According to the record this notification was at the family's request. c. Review of the weekly pressure ulcer progress report revealed on 5/28/09 the right heel pressure sore measured 3 cm by 3 cm, was black and had a scant odor. The left heel measured 2.6 cm by 2.5 cm and was black. Review of the 6/5/09 weekly pressure ulcer progress report revealed that on 6/5/09 the right heel pressure sore had increased in size to 6 cm by 3 cm, and had black eschar. The left heel also had increased to 6 cm by 3 cm. During an interview	F 314	The DON/designee will perform random audits of wound/treatment records and skin assessment. The results of these will be presented at monthly QA meetings.	July 3,2009

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

7/31/09 JL

PRINTED: 08/24/2009
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 08/10/2009

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 314	Continued From page 6 on 6/10/09 at 3:50 PM the director of nursing, who was a member of the wound team, stated both of these wounds had enlarged in size, and the resident's overall condition had declined.	F 314		
F 520 SS=H	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 by: Based on staff interview, medical record review, and review of facility documents, the facility failed to ensure the quality assurance performance improvement (QAPI) program was effective in preventing the development of pressure sores in	F 520	F520 483.75(c)(1) QUALITY ASSESSMENT AND ASSURANCE 1.Resident #5 has been discharged. 2. Resident #4 has been discharged. 3. Resident #1 is currently a resident at TRCC and though still has decubitus ulcers they have significantly decreased in size. (See 314 – 3) Monthly QA meetings will include a complete report related to wound and skin. If there is an increase in numbers of wounds or	

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

7/1/09

PRINTED: 06/24/2009
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 06/10/2009

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 7 the facility for three (#1, #4, #5) of eight sample residents who had pressure sores. The findings were: 1. Review of the admission face sheet for resident #5 showed s/he was admitted to the nursing facility on 1/9/09. Review of the 1/9/09 nursing admission assessment showed the resident had no pressure ulcers and his/her risk for skin breakdown was moderate. Refer to F314 for specific information regarding staff failure to prevent the development of avoidable pressures sores. 2. Review of the 1/9/09 admission physician orders for resident #4 revealed s/he had a diagnosis of fractured right femur. Review of the 1/9/09 admission nursing assessment revealed the resident had no pressure sores upon admission. Further review of this document revealed the resident was a moderate risk for skin breakdown. Refer to F314 for specific information regarding staff failure to prevent the development of avoidable pressures sores. 3. Review of the 10/6/08 annual Minimum Data Set (MDS) assessment for resident #1 revealed s/he was totally dependent on staff for all cares. Review of the medical record face sheet showed the resident was a patient in the hospital from 4/12/09 through 4/17/09, and, according to the 4/17/09 re-admission nursing assessment the resident had one pressure ulcer on the left heel, one on the right heel, and one on the coccyx. Refer to F314 for specific details regarding staff failure to adequately assess and monitor pressure sores which resulted in an increase in size and condition of pressure sores.	F 520	severity of wounds, a clinical committee will be created to participate in the assessment and improvement of the wound program. This committee will continue to be a part of the skin and wound team until the number and severity of wounds decline. This team will also provide reports to the monthly QA meeting for 3 months or until there is a decline in scope and severity of wound/skin problems. Each resident identified either at risk for or presenting with a wound will have a nutritional assessment completed. The result of this assessment will be provided to the physician with recommendations for nutritional supplements and/or vitamin supplements. the clinical committee is in place now, An action plan has been developed, and the protocol has been revised.	July 8, 2009

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

7/1/09

PRINTED: 06/24/2009
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 06/10/2009

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 8 4. Interview with the director of nursing (DON) and administrator on 6/10/09 at 3:50 PM revealed pressure sore monitoring was included in the morning stand-up meetings as well as in the QAPI program. The DON further stated the wound team performed weekly rounds to a portion of residents. She further stated a skin assessment was only performed if the team thought a resident might have a pressure sore and no skin measurements, staging, or wound team recommendations were completed; only a notation whether or not the resident had a pressure sore was noted. There was no evidence the QAPI program developed an action plan to address pressure sore prevention or worsening.	F 520		