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Wyoming Dept of Health
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Office of Healthcare Licensing and Surveys

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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 _____	R-C 01/23/2009

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 281) SS=D	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 interview and medical record review, the facility failed to ensure one (#4) of two sample residents was assessed after exhibiting increased shortness of breath. The findings were: Review of the medical record for resident #4 revealed s/he was hospitalized for aspiration pneumonia from 9/18/08 through 9/22/08. Review of the 10/1/08 quarterly Minimum Data Set assessment revealed the resident was short of breath and exhibited an inability to lie flat due to the shortness of breath. Further review of the medical record revealed the resident had an upper respiratory infection on 12/18/08. Review of the oxygen saturation levels revealed a level of 86% on 12/18/08 and 89% on 12/19/08. Review of the physician's order dated 9/25/08 revealed oxygen saturation levels were to be maintained above 92%. At the time of this observation, the resident did not have oxygen in place. The following concerns were identified: a. Observation on 1/21/09 at 4:47 PM revealed certified nurse aide (CNA) #9 entered the room of resident #4. As the CNA prepared to assist the resident from the recliner to a wheelchair, she stated to the resident, "You seem more short of breath today." The CNA proceeded to transfer the resident into the wheelchair and assisted him/her to the bathroom. While the resident was on the toilet, the CNA stated the resident was more short of breath than usual.	(F 281)	F210 - 483.20 (k)(3)(i) All nursing staff has been educated that if anyone notices a change in condition of any resident that they must report it to the charge nurse. The charge nurse will then assess that resident and seek appropriate medical intervention. The charge nurse will also make appropriate notation in the nurses notes and also note any interventions prescribed for the resident. All nursing staff has been inserviced that they must complete vital signs and document same on the vital signs sheet. All vital signs will be reported to the charge nurse. [redacted]	021209

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

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.

This POC accepted on 2/17/09 & agreed to through by Amy Tackett (surveyor) and Lee Cozzens (supervisor)

Facility ID: WY00003 If continuation sheet Page 1 of 1

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE

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This POC accepted 2/19/09 c agreed to change by [handwritten name] (surveyor) and [handwritten name] (administrator).

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(F 281)	Continued From page 1 Observation by the surveyor also revealed the resident appeared short of breath. Continued observation revealed the CNA provided perineal care, transferred the resident from the toilet to the wheelchair and assisted him/her into the dining room to await dinner. Observation revealed the CNA did not check the resident's vital signs or pulse oximetry; nor did she notify the nurse so an assessment could be performed. Interview on 1/23/09 at 9 AM with registered nurse (RN) #2 revealed she was unaware of the resident's increased shortness of breath. She further stated the CNA should have notified the nurse so an assessment could have been done, especially since the resident was recently treated for respiratory symptoms. According to The Long-Term Care Nursing Assistant, 2nd Edition, 2000, page 102 by Grubbs and Blasband, "You always must report your observations to your charge nurse. Changes in the resident must be reported immediately so that measures can be taken to prevent a more serious problem." b. Review of nurses' notes, dated and timed on 1/21/09 at 8 PM, revealed the resident had a low grade temperature (99.4 F) and nursing would monitor. According to the flow sheet where vital signs were documented, the resident's baseline temperature was 98.5 degrees F. Review of the medical record, including the vital sign flow sheet and nursing notes, revealed no follow-up assessments or vital signs had been taken as of the surveyor's record review on the morning of 1/23/09. Again, interview with RN #2 at 9 AM on 1/23/09 revealed she was unaware the resident was having any problems. According to Fundamentals of Nursing by Lippincott, Williams & Wilkins, Sixth Edition, 2008, page 557, if a person experienced a change in vital signs, the nurse should perform a further assessment to	(F 281)		

This POC accepted 2/19/09 & agreed to changes by Tony Hopkins (surveyor) and Dee Coppens (administrator).

amy

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{F 281}	Continued From page 2 determine if there was a change in overall health status. c. Review of the medication administration record for January 2009 revealed nursing scheduled oxygen saturation checks once per shift based on the physician's order to maintain the saturation level at above 92 %. However, review revealed the oxygen saturation level was not checked 30 out of a possible 63 shifts from 1/1/09 through 1/21/09. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician.	{F 281}		
{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 review of the plan of correction (PoC) for the 11/19/08 recertification survey, review of the fall risk committee notes, review of medical records, and staff interview, the facility failed to provide necessary care and services for 4 (#4, #19, #39, #44) of 6 sample residents with falls. The findings were: According to the PoC for the 11/19/08 recertification survey, the facility was going to establish a fall risk committee, which would discuss and assess each resident's fall "the day	{F 309}	*F309 - 483.25* *Quality of Care* *A fall committee has been established. The members of the committee are: The DON. Restorative Nurse and the Administrator. Additional information will be sought from the charge nurse and the CNA. The fall risk committee will discuss all new falls at the stand-up morning briefing. We have instituted a new post-fall evaluation form. This will be completed by the restorative nurse after each fall. This form will be placed in the resident chart under the assessment tab. (See attached form) The fall committee will make suggestions to increase the resident's safety. The physician will be notified of suggestions and orders will be requested if necessary.*	021209

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(F 309)	Continued From page 3 after" it occurred. The committee would also "request orders" from the physician for any new recommendations or interventions. A post fall risk assessment would "be completed by the charge nurse at the time of the fall" and immediate safety measures would be instituted at that time. Finally, the fall risk committee would "then assess the incident report and either continue the interventions or make recommendations to the physician for appropriate additional safety measures." The following concerns were noted related to oversight of the falls risk program: 1. Review of the nursing notes and incident reports showed resident #19 fell on 1/5/09 and 1/11/09. Even though the two falls were totally different, review of the fall risk assessments, completed on 1/6/09 and 1/12/09, showed they were identical. Neither risk assessment identified the causes or contributing factors related to the fall. Furthermore, additional safety measures were not instituted, and the care plan remained unchanged. Review of the fall risk committee notes showed the committee had not evaluated either fall by noon on 1/23/09. 2. Review of the 11/16/08 fall risk assessment for resident #44 revealed s/he was a high fall risk. Review of the medical record revealed the resident fell on 11/27/08 and on 12/13/08. Review of the medical record and fall committee records revealed there was no evidence an evaluation to determine the cause and contributing factors for the resident's falls was performed, nor was there evidence a post fall follow-up assessment was completed in a timely manner. The post fall assessment provided to the surveyor by the director of nurses (DON) was completed after the	(F 309)	1. *The incident report of Resident #19 has been reviewed for causes of recent falls. The care plan will be updated to reflect Resident #4's non-compliance with suggestions to prevent further falls.* #19 2. *The incident reports for 112708 and 121308 resident #44 will be reviewed using the new post fall evaluation form. Any new suggested interventions will be presented to the physician for agreement related to new interventions. The care plan will be updated to reflect the new interventions.*	

This POC accepted 2/13/09 & agreed to change by Tony Madden (Surveyor) and Lee Coggins (Administrator)

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(F 309)	Continued From page 4 surveyor asked to see what follow-up was completed. Interview with the DON and Minimum Data Set (MDS) assessment coordinator on 1/22/09 at 5:35 PM revealed the post fall assessment provided to the surveyor was just completed that evening. This was confirmed by interview with the MDS coordinator on 1/23/09 at 9:10 AM. 3. Review of the medical record for resident #4 revealed s/he fell at 5:30 AM on 11/26/08 and sustained a laceration to the back of the head with a large amount of bleeding. Review revealed the resident was transported to the emergency room for an evaluation and treatment. Review of the medical record and the fall committee records revealed there was no evaluation as to why the resident's knees buckled or why the CNA was unable to prevent the fall. Review also revealed there was no post fall follow-up evaluation. 4. According to the PoC for the 11/19/08 recertification survey, the facility would complete a post fall risk assessment for resident #39, and appropriate interventions would be instituted or continued. Review of that risk assessment, dated 12/16 (year not identified), revealed the resident was at high risk for falls; this information remained the same as that for the risk assessment completed on 6/2/08. The causes of the resident's fall remained unidentified, and interventions for the plan of care were unchanged. 5. On 1/22/09 at 11:30 AM the DON stated there was no further information from the fall risk committee. She confirmed the last meeting was on 1/5/09, and she stated the only available information was related to residents cited in the	(F 309)	*3. The incident report for resident #4 will be reviewed by the Fall Committee. A post fall evaluation will be completed. The Fall Committee will attempt to determine the cause of the fall. The care plan will be updated if there are any recommended interventions.* *4. Resident #39 (See Above)* *5. The full committee will complete notes for each fall. All falls will be discussed and minutes of the fall committee will be completed during each meeting.*	2/19/09

This POC accepted 2/19/09 & agreed to changes by Tony Madden (attorney) and Alice Coggins (administrator).

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{F 309}	Continued From page 5 deficiency written for the 11/19/08 recertification survey.	{F 309}		
{F 329} S8=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: Based on staff and resident interview and medical record review, the facility failed to ensure unnecessary medications were not administered to 2 (#11, #19) of 8 sample residents. The findings were: 1. Review of the physician's orders for resident	{F 329}	Unnecessary Drugs A new sleep assessment form by Nsg. Dept will be developed and each resident requiring sleeping medication will be assessed when the order is received and quarterly thereafter with the MDS quarterly/annual by the MDS coordinator assessment. A behavior sheet will be instituted for insomnia with non-pharmacological interventions listed. The resident receiving "as needed" sleep medication will offered non-pharmacological interventions prior to the administration of sleeping medication.	021209

This POC accepted 2/19/09 & agreed to changes by Jerry Hopkins (Surveyor) and Lee Conyers (administrator).

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{F 329}	Continued From page 6 #11 revealed the resident received Ambien CR 5 mg every night at bedtime for insomnia. Review of the entire medical record revealed there was no evidence a sleep assessment had beend done to determine the cause of the insomnia. Interview with registered nurse (RN) #2 on 1/23/09 at 9 AM confirmed there was no additional documentation to review. In addition, interview with the Minimum Data Set assessment coordinator on 1/23/09 at 9:10 AM also confirmed no documentation that a sleep assessment was done for this resident. 2. Review of orders for resident #19 revealed that on 1/7/09 the physician discontinued the nightly order for Ambien 2.5 milligrams (mg) at bedtime. In place of that order, the physician changed the Ambien to 2.5 mg as needed for sleep. Review of the January 2009 medication administration record showed the resident received Ambien on January 7th, 8th, 9th, 10th, 13th, 14th, 15th, 16th, 20th, and 21st. Review of the medical record revealed an incomplete sleep assessment completed on 11/20/09 as part of the plan of correction for the 11/19/08 recertification survey. The facility failed to determine the cause of the resident 's inability to sleep and non-pharmacological interventions were not addressed. On 1/23/09 at 11:10 AM, the DON confirmed the data had not been analyzed to determine the cause of the resident's sleeplessness.	{F 329}	1. A sleep assessment will be completed for resident #11. This assessment will be placed in the resident chart under the assessment tab. by the Charge Nurse 2. Resident #19 will have a sleep assessment completed. A behavior sheet with all non-pharmacological interventions listed will be placed in the medication administration record. Each time that a sleeping medication is requested by the resident, all non-pharmacological interventions will be offered and documented prior to administration of the sleeping medication. by the Charge Nurse	
{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}		1/15/09

This POC accepted 2/13/09 - agreed to changes by Tony Hopkins (Surveyor) and Lee Cozzens (Administrator)

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{F 444}	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure staff adhered to appropriate hand hygiene and infection control principles during observations of perineal care for 3 (#4, #19, #44) of 8 residents. In addition, dietary staff failed to practice appropriate hand hygiene during one of two observations in the kitchen. The findings were: 1. Observation on 1/21/09 at 4:15 PM revealed certified nurse aide (CNA) #3 assisted resident #44 to the toilet. The resident was incontinent of feces, and it was smeared on both buttocks and the toilet seat. Observation revealed after the CNA provided perineal care, she opened the bathroom door, pulled the wheelchair into the bathroom, pulled down the resident's shirt and pulled up his/her sweat pants, assisted him/her into the wheelchair and washed his/her face, all without removing her soiled gloves. Once these tasks were completed, the CNA removed her gloves, pushed the resident into the hallway, placed the soiled linen and trash in the soiled utility room, pushed the resident into the dining room, gave him/her a glass of water, poured a cup of coffee, added a non-dairy creamer, mixed it with a spoon, and handed it to the resident; all this was done without washing her hands after removing the soiled gloves. Interview with the CNA on 1/20/09 at 5:15 PM revealed she knew she should remove her gloves after perineal care, but she just "spaced" it. 2. Observation on 1/22/09 at 11:10 AM showed resident #19 was assisted into the bathroom by certified nurse aide (CNA) #4. Although the	{F 444}	021209 *F444 – 483.65 (b)(3)* *CNA #3 has been inserviced related to proper hand washing both as part of the group inservice conducted on 021009 and in a one on one instruction on 020409. The CNA verbalized understanding and completed a return demonstration.* *All nursing staff and dietary staff have been educated on 021009 related to proper infection control and washing hands, cleaning equipment properly, and washing residents hands after toileting. The dietary staff and nursing staff are no longer allowed to chew gum either during the preparation or service of food and before donning gloves and after doffing gloves.*	

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{F 444}	Continued From page 8 resident completed perineal care independently, the CNA provided it also. After assisting the resident to dress, the CNA removed her gloves and washed her hands. However, the CNA removed the resident from the bathroom without reminding or assisting him/her to wash his/her hands. When questioned immediately after the observation, the CNA stated the resident usually washed his/her hands independently. The CNA confirmed the resident failed to wash and stated she should have reminded him/her (the resident) to do so. After re-entering the room, the resident touched his/her face and several environmental surfaces while preparing for lunch. 3. Observation on 1/21/09 at 4:47 revealed CNA #9 assisted resident #4 to the toilet. After the CNA assisted the resident to the toilet seat, observation revealed the gait belt used by the CNA fell between the resident's legs into the perineal area where the resident had been incontinent of urine. The gait belt then was left hanging outside but against the toilet bowl. After the CNA provided perineal care and assisted the resident into the wheelchair, she removed the gait belt from the resident, folded it up and placed it into her pocket without washing or cleansing the gait belt. Interview with the DON on 1/23/09 at 9:30 AM revealed the CNA should have placed the soiled gait belt in the laundry for cleaning. 4. Observation on 1/21/09 at 2:15 PM revealed a dietary staff member spit chewing gum into her hand then threw it into the wastebasket. Without any handwashing, the dietary staff member then checked the temperatures of food that had been prepared for the evening meal.	{F 444}	*Audits will be completed on a random basis of nursing staff* by the DON, ADON, Administrator, and change needed to POC and will include residents #4, #19, and #44 *and dietary staff. The results of these audits will be presented at monthly QA meetings and a committee formed to further educate and monitor the results of these audits and present the results of further audits at the following Quality Assurance meeting.*	
{F 520} SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE	{F 520}		1/15/09

This POC accepted 2/19/09 c̄ agreed to changes by [illegible] (surveyor) and Dee Cozzens (administrator).

[illegible]

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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 _____	R-C 01/23/2009

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 9	{F 520}	F520 483.75 (o)(1)	021209

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 identifying and resolving problems in the facility. The findings were:

1. Review of the previous 11/19/08 survey findings revealed the facility was cited for not following professional standards of practice (F281). Review of the OSCAR 3 report revealed

Quality Assessment and Assurance

The Quality Assurance committee consists of the DON, Administrator, Medical Director and several other members of the leadership team. Failure of staff to meet the standards of compliance will result in further education of the staff member and discipline as indicated.

As stated above any survey issues not at 100% compliance will be assigned to a committee for further education and audits. The completed and results of these audits will be presented at the monthly QA meetings for 3 months and quarterly thereafter until the problem is resolved.

and other employees

This POC accepted 2/19/09 & agreed to changes by Tony Mabley (Surveyor) and Lee Coggins (Administrator).

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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 _____	R-C 01/23/2009

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 10 the facility also was cited for not following professional standards of practice during the 2004, 2005, and 2008 surveys. Refer to federal citation F281 for details related to concerns about not following professional standards during the current re-visit survey. 2. Review of the previous 11/19/08 survey findings revealed the facility was cited for not providing the necessary care and services to residents (F309). Refer to federal citation F309 for details related to concerns about not providing the necessary care and services regarding falls. 3. Review of the previous 11/19/08 survey findings revealed the facility was cited because unnecessary medications were administered (F329) to residents. Review of the OSCAR 3 report revealed the facility was cited for administering unnecessary medications also during the 2004 survey. Refer to federal citation F329 for details related to concerns about unnecessary medications and the lack of comprehensive assessments for resident #11 and #19. 4. Review of the previous survey findings dated 11/19/08 revealed the facility was cited for not following accepted handwashing practices (F444). Review of the OSCAR 3 report revealed the facility was also cited for improper handwashing practices during the 2008 survey. Refer to federal citation F444 for details related to concerns about staff handwashing practices during the current re-visit survey. 5. Interview with the DON and the administrator on 1/23/09 at 9:30 AM revealed they included previous survey results in their QAPI program.	{F 520}		

This POC accepted 2/13/09 & agreed to changes by Jay Madden (Surveyor) and Lee Conzens (Administrator).

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536051	A. BUILDING _____ B. WING _____	R-C 01/23/2009

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 11 However, they stated they continue to have some of the same problems.	(F 520)		

This POC accepted 2/19/09 = agreed to changes by Tony Madsen (Surveyor) and Dee Conyers (Administrator).

Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535051	A. Building B. Wing	01/23/2009

Name of Facility	Street Address, City, State, Zip Code
THERMOPOLIS REHABILITATION AND CARE CENTER	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 01/15/2009	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 01/15/2009	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 01/15/2009
ID Prefix F0258 Reg. # 483.15(h)(7) LSC	Correction Completed 01/15/2009	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/15/2009	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 01/15/2009
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 01/15/2009	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/15/2009	ID Prefix F0353 Reg. # 483.30(a) LSC	Correction Completed 01/15/2009
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/15/2009	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 01/15/2009	ID Prefix F0441 Reg. # 483.65(a) LSC	Correction Completed 01/15/2009
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 01/15/2009	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:		Date:
	B 1/23/09	1/26/09	Betty Dilson RN State Health Surveyor		
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**		

Followup to Survey Completed on: 11/19/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO