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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	**1210 CANYON HILLS RD THERMOPOLIS, WY 82443**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 3/9/23 through 3/10/23. The survey was prompted by complaint intakes WY00003547, WY00003549, and WY00003555. The following common abbreviations are used throughout this document: UTI- Urinary tract infection MDS- Minimum Data Set BIMS- Brief Interview for Mental Status ADLs- Activities of Daily Living MAR- Medication Administration Record THC- Tetrahydrocannabinol Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility medical records and	F 600	Preparation and execution of the	3/30/23

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

Electronically Signed | 03/30/2023

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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 hospital medical records, review of facility incident reports, review of the facility grievance logs, resident and staff interview, and review of facility policy and procedure, the facility failed to protect the resident's right to be free from deprivation of goods and services necessary to avoid physical harm and pain for 1 of 8 sample residents (#1) reviewed for abuse and neglect, and further failed to protect the resident's right to be free from verbal or mental abuse by a staff member for 1 of 8 sample residents (#2) reviewed for abuse and neglect. This failure resulted in harm to resident #1, who required evaluation at the emergency department and admission to the hospital for an indwelling urinary catheter that was degraded. The findings were: 1. Review of the admission MDS assessment dated 11/12/22 showed resident #1 was admitted to the facility on 10/12/22. The resident had a BIMS score of 13 of 15 indicating the resident was cognitively intact. Admission diagnoses included hypertension, viral hepatitis, seizure disorder, hepatic failure, cirrhosis of the liver, and indwelling urinary catheter. Review of the resident's care plan, undated, showed the resident required extensive assist of 1 person for ADLs, and had a Foley catheter, and cirrhosis of the liver with ascites. The following concerns were identified: a. Review of the nursing progress notes dated 3/5/23 as a late entry for 12:43 AM showed the resident was sent to the hospital emergency department by ambulance at approximately 11 PM for abdominal pain, and non-functioning Foley catheter. Attempts to flush the catheter were unsuccessful and the catheter was not draining. The resident's penis, scrotum and pubic area had increased pain and swelling.	F 600	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 statment of the deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of the state and federal law. For the purpose of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constuitutes the facility's allegation of the compliance in accordance to the State Operations Manual. F600- Corrective Action: - Resident #1 was discharged from facility 3/21/23. - Resident #2: resident continues to validate feeling safe as reported to the surveyor on 3/9/23. Former administrator was terminated following failure to comply with internal investigation. Identification of Others: - DNS/Designee will audit residents with catheters, completed 3/28/23. Any residents identified with Foley or suprapubic catheters will have orders updated to reflect catheter care by 3/28/23. - The Director of nursing or designee will interview alert and oriented residents to validate they feel safe at the center. Systemic Change: - DNS or designee will educate nursing staff that all new admissions with	

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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 b. Review of the medical record from the local hospital dated 3/5/23 showed the resident was seen in the emergency department for a blocked Foley catheter, and swelling and inflammation in the perineal area including the scrotum and penis. The records noted the resident's Foley catheter was badly deteriorated and the probable cause of the infection. The resident was admitted to the hospital for antibiotic therapy. The penis was so swollen the only access obtained was by inserting an 8 French (a small catheter usually used on small children) Foley. c. Interview with the risk management nurse at the local hospital on 3/10/23 at 1 PM revealed the resident's Foley catheter was in deplorable condition when the resident came to the emergency department, and when they asked the resident when it was last changed the resident indicated the catheter had not been changed since October, 2022. d. Interview with the resident while at the hospital on 3/10/23 at 1:20 PM confirmed the Foley catheter had never been changed at the nursing home, and that s/he had been admitted last October. e. Review of the resident's care plan, undated, showed "Foley catheter related to terminal condition of cirrhosis of liver with ascites" and interventions included "catheter changes as protocol". f. Review of the physician orders failed to show any specific orders for care of the Foley catheter. g. Review of the facility "standing orders" showed catheter care to be as directed by nursing staff. h. Interview with the interim administrator on 3/10/23 at 9 AM revealed the urinary catheter	F 600	catheters will have catheter care orders entered into PCC. DNS/designee will complete a x3 a week for 4 weeks audit to verify any new catheters orders for catheter care compliance. Existing catheters will be audited by DNS/designee for catheter care compliance. - Executive Director or designee will educate staff regarding reporting of suspected abuse. Director of Nursing or designee will report grievances during daily standup meetings and the Executive Director will review to determine if grievances reach a level of a reportable event, identified reportable events will be remitted to appropriate agencies upon discovery. ED/designee will review x3 a week for 4 weeks for compliance. - Previous administrator was terminated following failure to comply with internal investigation. Monitoring: - ED/DNS or designee will bring results of audits to facility QAPI meetings once a month x3 months to determine compliance and need for further monitoring.	

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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3	F 600		

care in this instance was very poor care and did not meet facility expectations.

2. Review of the admission MDS assessment dated 2/17/23 showed resident #2 was admitted to the facility with diagnoses which included diabetes mellitus, and anxiety disorder. Further review indicated the resident had a BIMS score of 15 of 15 indicating the resident was cognitively intact. The following concerns were identified:

a. Review of the facility grievance log indicated on 2/15/23 the resident complained the former administrator of the facility had approached the resident in his/her room and wanted the resident to take a particular medication for his/her blood sugar. The resident refused and expressed concerns about the medication. The resident reported the former administrator then indicated to the resident if s/he did not want to work with the facility to fix their condition s/he would be kicked out and have to go someplace else.

b. Interview with resident #2 on 3/9/23 at 3 PM revealed the grievance was accurate and reiterated the occurrence. Further interview revealed the resident had been a lifelong diabetic and felt the condition was controlled with Humalog (insulin). The resident regarded the former administrator's statement as a threat, but felt safe at the facility since the former administrator was no longer working at the facility. The resident stated the former administrator had also called his/her parents and threatened them in the same manner.

c. Review of the facility's 2/23/23 incident report showed the former administrator refused to be interviewed for the facility's investigation of this incident, and her employment was terminated.

d. Interview with the interim administrator on

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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 3/10/23 at 9 AM confirmed that "verbal or mental abuse would not be tolerated" and that was the expectation for all of their facilities. 3. Review of the facility policy titled, "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation" updated October 2022, showed "Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse ...neglect ...The center implements policies and processes so that residents are not subjected to abuse by staff ..." and " ...Neglect: Failure of the Center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish, or emotional distress."	F 600		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		3/30/23

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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 Based on medical record review, resident and staff interview, and review of facility investigation documentation, the facility failed to ensure residents received medication according to physician order for 2 of 8 sample residents (#1, #5) reviewed for medication administration. The findings were: Interview with the interim administrator on 3/9/23 at 10:30 AM revealed when they took over interim supervisory operation at the nursing home they received complaints about the "special cream" being used on residents and its nature, and investigated on 2/19/23. Further interview confirmed the cream had been used on resident #1 and resident #5. Review of the facility's investigation showed the former administrator had applied an ointment called "Dragon Balm" to residents #1 and #5. Law enforcement were called and tested the ointment, which was determined to contain significant levels of THC. The ointment was taken by law enforcement as evidence. The following concerns were identified: 1. Review of the February, 2023 MARs for residents #1 and #5 showed no evidence of a physician's order for "Dragon Balm" ointment. 2. Review of the admission MDS assessment dated 11/12/22 for resident #1 showed the resident was admitted to the facility on 10/12/22. The resident had a BIMS score of 13 of 15 indicating the resident was cognitively intact. Interview with the resident on 3/10/23 at 1:20 PM revealed the resident did not know what medications s/he took, or what ointments or creams might have been applied.	F 684	Preparation and execution of the 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 statment of the deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of the state and federal law. For the purpose of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constuitutes the facility's allegation of the compliance in accordance to the State Operations Manual. F684- Corrective Action: - Resident #1 was discharged from the facility on 3/21/23. - Resident #5 medication orders were reviewed on 3/28/23 Identification of Others: - No other residents were affected per investigation completed 2/23/23, DDCO. Systemic changes: - DNS and or designee educated licensed Nurses to validate medications are administered according to the Physicians Order. DNS/designee will complete a medication administration observation audit x3 a week for 4 weeks to ensure compliance with medication administration. Monitoring: - DNS or designee will bring results of audits to facility QAPI meetings once a	

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 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	**1210 CANYON HILLS RD THERMOPOLIS, WY 82443**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 3. Review of the quarterly MDS assessment dated 12/19/22 for resident #5 showed the resident was admitted to the facility on 5/19/22. The resident had a BIMS score of 15 of 15 indicating the resident was cognitively intact. Interview with resident #5 on 3/9/23 at 2:30 PM revealed s/he knew exactly what medications the facility was administering to him/her, because s/he insisted on being told. In further interview the resident declined to discuss their medications further. 4. Interview with the interim administrator on 3/9/23 at 10:30 AM confirmed the facility expectation that all medications administered to residents must be ordered by a physician.	F 684	month x3 months for review to determine compliance and need for further monitoring.	