STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/18/2023. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039		5/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 1 this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 2 to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 3 challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 4 plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 5 (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 6 [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 7 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 8 following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct testing of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(2). Failure to	E 039	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
E 039	Continued From page 9 conduct testing of the EPP could result in inadequate preparedness of staff in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 4/18/2023 starting at 12:50 PM revealed that the facility did not have documentation available to demonstration that a full-scale test of the EPP had been conducted in the last twelve (12) months. The facility had documentation showing that a table-top exercise had been conducted in December of 2022, but no additional information was available to demonstrate that a full-scale exercise had been conducted, or that the EPP had been activated in the last twelve months. Interview with administrator at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	E 039	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 the state and federal 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 the State Operations Manual. 1. Maintenance assistant or designee will conduct a full-scale emergency test of the EPP on or before 5/31/23. 2. Maintenance assistant or designee will conduct a full-scale emergency test of the EPP on or before 5/31/23. 3. Regional maintenance director or designee will re-educate the maintenance assistant and the executive director on the requirements of emergency preparedness policy including conduction 2 exercises per year one of which needs to be a full-scale test on or before 5/20/23. 4. Executive Director or designee will review the emergency preparedness testing to validate 2 tests have occurred during a 12-month period including 1 full test quarterly x4 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 000	Continued From page 10 Healthcare Licensing and Surveys on 04/18/2023. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V(000) construction with a basement built in 1954, and additions of the same construction type built in 1985 and 1990. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 40 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress width in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the	K 232	K232 Aisle, Corridor, or Ramp Width 1. Maintenance assistant or designee moved the chairs out of the corridor adjacent to the whirlpool room 46 on	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 232	Continued From page 11 means of egress width could result in a slow or inability to egress, which could result in injury or death in the event of an emergency requiring evacuation. The deficiency affected one (1) of multiple corridors used by staff, patients, and visitors. The findings were: Observation on 04/18/2023 at 11:13 AM revealed multiple chairs located in the corridor adjacent to the "Whirlpool room 46". Observation of the corridor revealed three (3) chairs all located on one side of the corridor and all projecting approximately 2 feet into the corridor's 8 foot width. The chairs were not secured to the floor or wall. All corridors are protected by an electronically supervised automatic smoke detection system. Where corridors are 8 feet in width, fixed furniture that is securely attached to the floor or wall and do not reduce the clear corridor width to less than 6 feet may be permitted. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.2.3.4(5)	K 232	4/18/23. 2. Maintenance assistant or designee will validate other corridors do not have items obstructing the corridors on or before 5/31/23. 3. Regional maintenance director will educate maintenance assistant and ED on the requirements of unobstructed corridors, including chairs free standing in corridors on or before 5/20/23. 4. ED or designee will view all corridors to validate corridors are unobstructed weekly x4 weeks, then monthly x3 months. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 324	Continued From page 12 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 96, Standard for the Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking facilities could result in the spread of smoke and fire, which could result in injury or death. The deficiencies affected the kitchen, and could impact all staff and visitors within the kitchen. The findings were:	K 324	K324 Cooking Facilities 1. Maintenance assistant or designee contacted the kitchen hood exhaust and duct system company to set up semi-annual inspections. 2. Maintenance assistant or designee contacted the kitchen hood exhaust and duct system company to set up semi-annual inspections. Next semi-annual inspection is scheduled for June 2023. 3. Regional maintenance director or designee will educate maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 324	Continued From page 13 Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to inspect the kitchen hood extinguishing system as required. Documentation revealed that the kitchen hood extinguishing system had been inspected in December of 2022, but no additional information was available to demonstrate the extinguishing system had been tested six months prior. Kitchen hood extinguishing systems shall be inspected once every six (6) months. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.5 Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to inspect the kitchen hood exhaust and duct system as required. Documentation revealed that the kitchen hood exhaust and duct system had been inspected in February of 2023, but no additional information was available to demonstrate the kitchen hood exhaust and dust system had been inspected six (6) months prior. Kitchen hood exhaust and duct system shall be inspected once every six (6) months and cleaned as needed. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement.	K 324	assistant and ED on requirements on testing kitchen hood extinguishing including testing every 6 months and inspection of kitchen hood exhaust and duct system on or before 5/20/23. 4. ED or designee will review maintenance logs to validate kitchen hood extinguishing system testing occurs every 6 months and the kitchen hood exhaust and duct system inspection every 6 months, quarterly x4 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 324	Continued From page 14 Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.4	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to activate the fire alarm system as required. At the time of the survey no documentation was available to	K 345	K345 Fire Alarms System-Testing and Maintenance 1. Facility was unable to correct the lack of activation of the fire alarm system as required or the lack of load testing and inspecting the fire alarm batteries prior to Dec 2022. 2. Maintenance assistant or designee will add fire alarm system activation to monthly tasks and load testing and inspection of fire alarm system batteries every 6 months on or before 5/31/23. 3. Maintenance regional director or designee educated maintenance assistant and ED on requirements of monthly activation of the fire alarm system and load testing and inspection of fire alarm system batteries on or before 5/20/23.	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 345	Continued From page 15 demonstrate that the fire alarm system had been activated from the month of October of 2022 to February of 2023. Fire alarm systems shall be activated every month. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(24) Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to inspect and test the fire alarm system batteries as required. At the time of the survey no documentation was available to demonstrate that the fire alarm system batteries had been inspected and load voltage tested twice in the last twelve (12) months. Documentation revealed that the batteries had been inspected and load tested in December of 2022, but no additional information was available to demonstrate the batteries had been inspected and tested 6 months prior. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	K 345	4. ED or designee will review maintenance logs to validate monthly activation of fire alarms systems and load testing and inspection fire alarm system batteries occurred, monthly x3, then quarterly x3 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days 5. 5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 345	Continued From page 16 Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system, and has the potential to affect	K 353	K353 Sprinkler System-Maintenance and Testing 1. Facility will contact contractor regarding the sprinkler head inspection by 05/31/2023. 2. Facility will contact contractor regarding the sprinkler head inspection by 05/31/2023. 3. Regional maintenance director or designee educated maintenance assistant and ED on requirements of testing or	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 353	Continued From page 17 all residents, staff, and visitors. The findings were: Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to test aging sprinklers as required. Documentation revealed that a large portion of the fire sprinkler system had sprinkler heads greater than 50 years old, and some dry sprinkler heads greater than 10 years old that had not been tested. Sprinkler heads greater than 50 years old, shall be either tested or replaced, and dry sprinkler heads greater than 10 years shall be either tested or replaced. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.5.1, 9.7.1.1; 2011 NFPA 25 5.3.1.1.1 & 5.3.1.1.1.6	K 353	replacing sprinkler heads greater than 50 years old and testing or replacing dry sprinkler heads greater than 10 years old on or before 5/20/23. 4. ED or designee will review maintenance logs to validate sprinkler heads have been tested or replaced if greater than 50 years old and dry sprinkler heads greater than 10 years old, quarterly x 4 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 355	K355 Portable Fire Extinguishers	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 355	Continued From page 18 facility failed to inspect and maintain portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to properly inspect and maintain portable fire extinguishers could result in the fire extinguishers working improperly, which could result in injury or death in the event of a fire. The deficiency affected all portable extinguishers in the facility, and has the potential to affect all residents, staff, and visitors. The findings were: Observation on 04/18/2023 starting at 11:00 AM, and throughout survey, revealed that the portable extinguishers had not been inspected in the months of January and February of 2023. Observation of the tags on the extinguishers revealed that the annual inspections had been conducted in December of 2022, but the tags showed no monthly inspections until March of 2023. Portable extinguishers shall be inspected every month. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.5.5.12, 9.7.4.1; 2010 NFPA 10 7.2	K 355	1. Maintenance assistant or designee validated that other portable extinguishers were current with the monthly inspection on or before 5/31/23. 2. Maintenance assistant or designee validated that other portable extinguishers were current with the monthly inspection on or before 5/31/23. 3. Regional maintenance director or designee educated maintenance assistant and ED on requirements of monthly testing of portable extinguishers on or before 5/20/23. 4. ED or designee will examine 5 fire extinguishers to validate monthly testing has been completed weekly x4, then monthly x 3 months. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 712	Continued From page 19 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in the improper response from residents, staff, and visitors in the event of a fire, which could result in injury or death. The deficiency affected all residents, staff, and visitors. The findings were: Document review on 04/18/2023 starting at 12:00 PM revealed that facility failed to conduct fire drills as required. No documentation was available at the time of the survey to demonstrate that fire drills had been conduct for the 4th quarter of 2022. Fire drills shall be conducted quarterly on each shift to familiarize staff with the signals and emergency action required. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement.	K 712	K712 Fire Drills 1. Maintenance assistant or designee added monthly fire drills with varied shifts to monthly maintenance duties on or before 5/31/23. 2. Maintenance assistant or designee added monthly fire drills with varied shifts to monthly maintenance duties on or before 5/31/23. 3. Regional maintenance director educated the maintenance assistant and ED on the requirements of holding fire drills on varied shifts each quarter on or before 5/20/23. 4. ED or designee to review maintenance logs to validated fire drills have been held on varied shifts each quarter, monthly x3 months, then quarterly x3 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 712	Continued From page 20 Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain electrical receptacles in accordance with the 2012 NFPA 99, Health Care Facilities. Failure to properly test and maintain electrical receptacles could result in a failure of the receptacles, which could result in injury or death. The deficiency affected all	K 914	K914 Electrical Systems-Maintenance and Testing 1. Maintenance assistant or designee tested non-hospital grade receptacles at patient bed locations on or before 5/31/23. 2. Maintenance assistant or designee add testing of non-hospital grade	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 914	Continued From page 21 non-hospital grade electrical receptacles at the patient bed locations, and could potentially affect all residents. The findings were: Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to test all non-hospital grade receptacles at patient bed locations as required. No documentation was available at the time of the survey to demonstrate that testing of the non-hospital grade receptacles at patient bed locations has not been conducted in the last twelve months. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.3.4.1.3, 6.3.3.2	K 914	receptacles at patient bed locations to preventive maintenance logs on or before 5/31/23. 3. Regional maintenance director or designee educated maintenance assistant and ED on the requirements of testing non-hospital grade receptacles at patient bed locations no greater than 12 months apart on or before 5/20/23. 4. ED or designee will review maintenance logs to validate testing of non-hospital grade receptacles at patient bed locations have occurred with 12-month interval, monthly x3 months, then quarterly x3 quarters. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 918	Continued From page 22 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system which could injury or death in the event of a power outage. The deficiencies affected the EES and could potentially affect all residents, staff, and visitors. The findings were:	K 918	K918 Electrical Systems-Essential Electric Systems 1. Maintenance assistant or designee tested the emergency electrical generator lead-acid batteries, inspected the emergency electrical generator, and completed a 4-hour load test of the emergency electrical generator on or before 5/31/23. 2. Maintenance assistant or designee added monthly testing of the emergency electrical lead-acid batteries, weekly inspection of the electrical generator, and 4-hour load testing every 36 months to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 918	Continued From page 23 Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to test the emergency electrical generator lead-acid batteries as required. No documentation was available at the time of the survey to demonstrate that the specific gravity, or conductance was being testing on the emergency electrical generator batteries. Lead-acid batteries associated with the emergency electrical generator shall be tested monthly for either specific gravity or for conductance. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.3.7.1 Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to inspect the emergency electrical generator as required. No documentation was available at the time of the survey to demonstrate that the emergency electrical generator had been inspected the months of December 2022 through February of 2023. Emergency electrical generators shall be inspected weekly. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement.	K 918	maintenance logs on or before 5/31/23. 3. Regional director of maintenance or designee educated maintenance assistant and ED on requirements of testing the generator including monthly testing of the emergency electrical lead-acid batteries, weekly inspection of the electrical generator, and 4-hour load testing every 36 months on or before 5/20/23. 4. ED or designee will review maintenance logs to validate monthly testing of the emergency electrical lead-acid batteries, weekly inspection of the electrical generator, and 4-hour load testing every 36 months occurred, weekly x4 weeks, then monthly x 3 months. ED or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly for 90 days. 5. 5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING **02** B. WING _____	**04/18/2023**

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
K 918	Continued From page 24 Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.4.1 Document review on 04/18/2023 starting at 12:00 PM revealed that the facility failed to test the emergency electrical generator as required. No documentation was available at the time of the survey to demonstrate that the 4-hour load test of emergency electrical generator had been conducted in the last 36 months. A continuous 4-hour test at a minimum of 30 percent load shall be conducted once every 36 months. Interview with the maintenance manager at the time of the observation acknowledge the deficiency, but indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.4.1.1.6.1; 2010 NFPA 110 8.4.9	K 918		