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 _____	04/20/2023

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 recertification survey was conducted by Healthcare Licensing and Surveys from 4/18/23 to 4/20/23. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set mg-milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		5/31/23

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

Electronically Signed | 05/12/2023

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F 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a written notice of transfer was provided to the resident or	F 623	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by	

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F 623	Continued From page 3 resident's representative for 2 of 2 sample residents (#36, #41) who were hospitalized. The findings were: 1. Review of progress notes showed resident #36 was transferred to the hospital on 4/11/23. The resident returned to the facility on 4/17/23. Review of the medical record showed a copy of a "Facility notice of Discharge" form that was e-mailed to the Ombudsman on 4/13/23. However, there lacked evidence the resident or resident's representative received written notice of the transfer. 2. Review of progress notes showed on 3/20/23 resident #41 was transferred to the emergency room. A progress note dated 3/21/23 showed the resident was admitted to the hospital, and would be discharged to hospice care in another city. Review of the medical record showed a copy of a "Facility notice of Discharge" form that was e-mailed to the Ombudsman on 3/23/23. However, there lacked evidence the resident or resident's representative received written notice of the transfer/discharge. 3. During an interview on 4/20/23 at 10:25 AM the assistant executive director stated the facility had a "Resident Notice of Transfer or Discharge Form" but they only issued that form if the resident was transferring "for good." She stated they did not provide the form to residents or the resident's family for transfers to the hospital.	F 623	the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of 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. F623 Notice of requirements before transfer/discharge 1. Facility was unable to correct the lack of providing resident #36 and #41 a transfer/discharge notice upon sending residents to the hospital. Resident #36 discharged on 4/22/23. Resident #41 discharged on 3/20/23. 2. Director of Nursing or designee will validate other residents transferred or discharged from facility have the proper transfer/discharge notification on or before 5/31/23. 3. Director of Nursing or designee will re-educate licensed nurses on requirements of transfer/discharge notifications including providing residents or resident representatives with a notification of transfer/discharge that includes ombudsman information on or before 5/20/23. 4. Director of Nursing or designee will review discharges/transfers to validate residents transferred or discharged from facility have the proper transfer/discharge	

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F 623	Continued From page 4	F 623	notification weekly x4, then monthly x3. DNS or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly. 5. 5/31/23	
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure ostomy care was provided according to the care plan for 1 of 1 residents with an ostomy (#24). The findings were: 1. Review of the quarterly MDS assessment dated 2/17/23 showed resident #24 entered the facility on 10/18/22 and had a BIMS score of 15 out of 15, indicating intact cognition. Bowel elimination showed the resident had an ostomy. The diagnoses included personal history of malignant neoplasm of large intestine, diabetes mellitus, and muscle weakness. Review of the current care plan showed and intervention last revised on 12/2/22: "Monitor Colostomy every shift and as needed; dressing change per protocol. Provide Colostomy care and monitor for any skin breakdown", and an intervention last	F 691	F691 Colostomy, Urostomy, or Ileostomy Care 1. Director of Nursing or designee obtained an order for ostomy monitoring on 4/19/23 and ostomy care on 4/20/23 for resident #24. 2. Director of Nursing or designee validated other residents with ostomies had orders for monitoring and ostomy care on or before 5/31/23. 3. Director of Nursing or designee will re-educate licensed nurses on requirements of ostomies including obtaining orders for monitoring and caring for ostomy on or before 5/20/23. 4. Director of Nursing or designee will review other residents with ostomies to validate ostomy orders have been obtained to provide care and monitoring	5/31/23

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F 691	Continued From page 5 revised on 10/27/22: "[Resident name] has an alteration in gastro-intestinal status r/t [related to] Colostomy (history of Colon Cancer) and GERD. [Resident name] will remain free from discomfort, complications or [signs and symptoms] s/sx related to gastro-intestinal alterations through review date. The following concerns were identified: a. Observation on 4/18/23 at 10:41 AM showed the resident had an ostomy. Interview at that time with the resident revealed s/he was admitted to the facility with the ostomy. b. Review of the physician orders showed there were no orders for the ostomy care. c. Review of the progress notes showed the last entry related to the ostomy was dated 3/5/23 at 5:42 PM "Wafer and bag changed once this shift," showing 43 days without written documentation of ostomy care. Review of the treatment administration record (TAR) showed no evidence of monitoring the ostomy. Review of the weekly skin assessment reports showed no evidence of an ostomy site skin assessment. d. Interview with the assistant executive director on 4/19/23 at 6:31 PM revealed there was no order for the ostomy care, and the care plan really did not address the ostomy. e. Interview with the assistant executive director on 4/20/23 at 9:15 AM revealed the skin assessments would not show the ostomy because it was pre-existing and not new. Further, she revealed she was unable to find a facility policy and procedure for ostomy care.	F 691	weekly x4, then monthly x3. DNS or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly. 5. 5/31/23	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		5/31/23

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F 758	Continued From page 6	F 758		

affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 7 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents received a gradual dose reduction (GDR), unless contraindicated, for psychotropic medication for 1 of 5 sample residents (#5) reviewed for unnecessary medications. The findings were: 1. Review of the 2/25/23 quarterly MDS assessment showed resident #5 had diagnoses that included non-Alzheimer's dementia and anxiety disorder. Further, the resident received an antipsychotic on 7 days during the look-back period and a GDR was not attempted, nor did the physician document a contraindication. Review of physician orders showed the resident received Ziprasidone HCl (antipsychotic, brand name Geodon) 60 mg once per day plus 40 mg once per day since 7/26/22. The following concerns were identified: a. Review of the medical record showed no evidence a GDR of the Ziprasidone HCL was attempted. b. Review of a physician's progress note dated 2/14/23 showed "Pharmacy review performed with recommendation GDR Geodon. The patient has been decreased to 40 mg BID [twice per day] in the last several days." However, review of the physician orders and the medication administration record (MAR) for February, March and April 2023 showed the resident remained on Ziprasidone HCL 60 mg once per day and 40 mg	F 758	F758 Free from Unnecessary Psychotropic Meds 1. Director of Nursing or designee obtain a Geodon GDR for resident #5 on 4/19/23. 2. Director of Nursing or designee will validate other residents who take psychotropic medications have GDR recommendations on or before 5/31/23. 3. Divisional Director of Clinical Services or designee re-educated DNS and licensed nurses on requirements of psychotropic medications and dose reductions on or before 5/20/23. 4. Director of Nursing or designee will review 5 residents receiving psychotropic medications to validate GDR□s are current weekly x4, then monthly x3. DNS or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly. 5. 5/31/23	

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F 758	Continued From page 8 once per day. c. On 4/20/23 at 9:05 AM the assistant executive director stated she called the physician's office on 4/19/23. She stated he had a signed response to a pharmacy recommendation from February 2023 regarding the Geodon in his office. However, she stated neither the facility nor the pharmacist had received the response. She stated the physician's office faxed the response to them last night. d. Review of the faxed "Consultant Pharmacist Recommendation to Physician" showed "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. This resident has been taking Geodon 60 mg am and 40 mg pm since July 2022 without a GDR..." The physician's written response was to reduce the dose of Geodon to "40 mg po bid." The physician signed it 2/13/23.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		5/31/23

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F 761	Continued From page 9 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure medications for resident use were not expired in 1 of 3 medication storage units (secure unit medication cart). The findings were: 1. Observation on 4/19/23 at 2:44 PM of the secure unit medication cart with LPN #1 showed 54 tablets of hydrocodone-acetaminophen 5-325 mg tablets had expired 3/2023. Interview with the LPN at that time confirmed the medication was for resident use and expired. 2. Interview with the DON on 4/19/23 at 2:54 PM revealed it was the expectation for the nurses to check the expiration date and dispose of the medication if expired. 3. Interview with the assistant executive director on 4/19/23 at 4:51 PM revealed the facility did not have a policy related to prescription medication expirations.	F 761	F761 Label/Store Drugs and Biologics 1. Director of Nursing and nurse on unit destroyed the expired narcotic upon discovery on 4/19/23. 2. Director of Nursing or designee validated that other medications in the medication carts were not expired on or before 5/31/23. 3. Director of Nursing or designee re-educated licensed on requirements of medication storage including checking the medications to ensure the medications are not expired on or before 5/20/23. 4. Director of Nursing or designee will check medication carts, treatment carts, and medication storage areas to validate medications are not expired weekly x4, then monthly x3. DNS or designee will bring the audit results to QAPI on or before 5/31/23 to identify trends and sustainability, then monthly. 5. 5/31/23	