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	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thermopolis Rehabilitation and Wellness	1210 Canyon Hills Rd Thermopolis, WY 82443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on observation, medical record review, review of an incident timeline, family and facility staff interview, interview with hospital staff, policy and procedure review, review of an emailed update, and review of professional standards, the facility failed to protect the resident's right to be free from neglect. Specifically, the facility failed to provide timely interventions consistent with professional standards for 1 of 1 residents with significant burns (#1). This failure resulted in a delay in transfer to a burn center for assessment and intervention by qualified staff, and a determination of immediate jeopardy. The census was 45. The findings were: 1. Review of the 11/24/22 quarterly MDS assessment showed resident #1 had diagnoses which included diabetes mellitus, atrial fibrillation, coronary artery disease, hypertension, and non-Alzheimer's dementia. The assessment showed the resident had no pressure ulcers or other skin conditions at that time. The resident's brief interview for mental status could not be completed due to severe cognitive impairment, and s/he required the extensive assistance of one staff person for bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed). Review of the resident's care plan showed an 8/31/21 plan related to diabetes mellitus with an intervention to avoid exposure to extreme heat and cold. 2. Interview with CNA #4 on 1/10/23 at 6:25 PM revealed she was working the morning of 1/7/23, and found the resident between 3:45 AM and 4 AM with the bed pushed from the wall and the resident's feet on the heater unit with the vent cover missing, so both feet were on the fins and pipes (the hot elements) within the heater unit. It was apparent that the resident's feet were both burned in areas with some peeled skin and some blood, so she got the resident's feet away from the hot elements and onto the bed, and called for the nurse, who arrived promptly. The CNA had last checked on the resident during rounds at around 1:45 AM. She had no experience with burns, but could tell the resident's feet had burns. The resident did not appear to be in pain, but did rub the feet together, so the CNA continued to prevent that. When the nurse arrived she took over, and they placed the bed away from the wall and secured the bed wheel brakes, that had not been not locked in place. The CNA said the brakes should have been on, and she was not sure why that was not the case. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Interview with LPN #1 on 1/10/23 at 6:05 PM revealed she came to the resident's room at about 4:15 AM on 1/7/23 promptly after staff alerted her there was an issue. CNA #4 was with the resident and the resident was in bed. The LPN noticed the resident's feet were burned bilaterally. She saw blood and areas on both feet that were obviously burned. She said she had no experience with burns. She ensured the resident's feet were on the bed, then notified the ED/RN at around 4:25 AM rather than calling the physician or the emergency department. The ED/RN arrived approximately 30 minutes later, and the ED/RN took over. 4. Review of a 1/7/23 nursing progress note timed 10:01 AM as a late entry showed, [ED/RN] was called at 0430 [4:30] AM to return to the building due to resident burns. Resident was on [his/her] bed when [ED/RN] arrived. [His/her] feet bilaterally had 2nd degree burns .Right foot-lateral aspect of the foot from toe to arch 16x13 cm [centimeters] with the epidermis removed. The 5th, 4th, and 3rd toe are involved. 4-5th from tip to base 3rd 1.5 cm. Was cleaned and then covered with Silvadine, telfa, abd [abdominal pad], kerlix, and then an ace wrap. Left [foot]-from medial aspect of foot 9x4cm including first toe with epidermis removed red in color. Where that end (over the arch) 2x3 blister filled fluid. This area too was covered in Silvadine, telfa, abd, kerlix, and ace wrap. POA, DNS was notified. MD [DO #1] was notified and orders given for wound care treatment, abx [antibiotics] and supplements to aide in healing due to the resident's medical condition. Resident will be monitored for infection, Tylenol will be given for pain. MD did not think the resident needed to go to the ER. Family agreed. 5. Interview with the ED/RN on 1/10/23 at 4:45 PM revealed she received a call from the facility on 1/7/23 at around 4 AM regarding the resident having burned [his/her] feet on the heat vent by the bed. She arrived in approximately 30 minutes and it was apparent the resident had burned both feet, which she felt included some 2nd degree burn areas. She noticed the heat vent cover was off, exposing the hot pipes and fins. She cleansed the resident's feet with normal saline (NS) and wrapped them, then called the local emergency department and found out DO #1 was the physician on call (for both the facility and the emergency department), then made several attempts to contact DO #1. When she did contact DO #1, she sent pictures of the resident's bilateral foot burns to DO #1 on her phone. DO #1 felt the ED/RN was best trained to care for the resident's burns, not the local emergency department. DO #1 gave orders for wound care. 6. Review of the wound care certification information for ED/RN confirmed she was wound care certified with an expiration date of 5/26/2026. However, interview with the ED/RN on 1/13/23, at 1:55 PM revealed that while she was once certified in burn care, she had not been certified in burn care for the last 6 years. 7. Review of the facility policy titled, Change of Condition published May 2017, under Policy Statement: . Changes in condition are documented in the resident's record, and the resident is monitored via alert charting. If it is determined that the resident's condition is unstable and/or beyond the scope of services provided by the community, the resident is transferred to the hospital for evaluation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Review of a timeline of the event provided by the facility showed the ED/RN unsuccessfully attempted to speak with the physician at the local emergency department 5 times between 4:50 AM and 9 AM. At 9:42 AM (over 5 hours after the burns were discovered), the emergency room physician, DO #1, called back, and the ED/RN explained the resident had sustained 2nd degree burns to both feet. The ED/RN sent photos of the injuries to DO #1. Orders were received to dress the resident's feet and add a multivitamin, vitamin C, and Arginaid (a supplement intended to help with wound healing) to the resident's medications. According to the timeline, it was DO #1's opinion that nothing different would be done at the hospital, and the resident should be kept at the facility to decrease the anxiety of transfer. At 11:36 AM, the ED/RN called the facility's medical director regarding the resident's burns. At that time, the medical director provided an order for Keflex (an antibiotic), but did not intervene to send the resident to the emergency department. 9. Review of the American Burn Association's Burn Center Referral Criteria found at http://ameriburn.org/wp-content/uploads/2017/05/burncenterreferralcriteria.pdf and retrieved on 1/13/23 showed Burn injuries that should be referred to a burn unit include: . 2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints .3. Third degree burns in any age group . 7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality . 10. Review of the nursing progress note dated 1/8/23 and timed at 3:16 PM showed Family had called early AM asking that the resident be sent to the ER (emergency room) for evaluation. [ED/RN] spoke with [emergency room doctor - DO #1] and she did not feel the need to have [the resident] taken out in the cold and disrupt [his/her] routine because [s/he] was getting the needed care in the facility. [DO #1] called the [POA] and explained all this to [the POA] and the appropriate care that [the resident] needed and that the ER would do nothing different for [the resident] and that it is not an admitting dx [diagnosis]. [The POA] then called ED/RN and explained they did not have confidence in [DO #1] and what other measures could be taken. ED/RN explained the medical director could be called .and asked if he would come in and check the resident. They agreed to that. Messages left for [the medical director]. After 2 hours of no response from [the medical director] ED/RN called the [POA] and asked what the next steps needed to be. It was explained that the dressings needed to be changed. The POA stated [s/he] would like to come in and look at the feet [him/herself]. ED/RN waited for family to arrive and then proceeded with the dressing change. The wounds on the feet looked a lot better today they are pink red in areas . both no change in size other than the skin around the edges needed to be removed. Resident had +1 edema in the left foot and will work on keeping feet elevated. The right outer foot is the largest with no blisters 5-4-3 toe remains unchanged. Left inner aspect of the foot is the affected area with only the 1st toe burned. All area's pink red and moist. Skin on the edges of the toe wound needed removed. Both feet were cleansed with NS (normal saline), Silvadine was placed on the burned area, followed with telfa abd ace wrap. Resident tolerated dressing change without crying out. Will continue daily dressing change. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Continued review of the timeline of the event provide by the facility showed on 1/8/23 between 8:30 AM and 12 PM, the resident's POA texted the facility requesting the resident be sent to the emergency room for evaluation. The ED/RN called the POA and explained they would be glad to send the resident, and they would inform DO #1, who was the physician on call at the emergency room . The POA informed the facility they wanted the resident to be evaluated by a different physician, and asked about sending the resident to a hospital in a different town. It was explained to the POA that the facility could call emergency medical services (EMS) to transport the resident, however, EMS would be required to take the resident to the local emergency room . The ED/RN told the POA she had been in contact with the facility's medical director, and could ask the medical director to come and see the resident. The POA agreed to this. At 12 PM, the RN/ED messaged the medical director to ask if he would stop in and see the resident. At 3:40 PM, the medical director called and informed the facility he was out of town, and could come to see the resident after he had returned home, or Monday or with rounds on Tuesday. The timeline further showed the ED/RN called the resident's POA at 3:45 PM and told the POA what the medical director had offered. According to the timeline, the POA told the ED/RN the medical director did not need to come in that night, and agreed the medical director could see the resident on Monday or Tuesday. Tuesday was decided and agreed upon by all. 12. Interview with the ED/RN on 1/11/23 at 12:10 PM confirmed she initially thought the resident's bilateral burns had some 2nd degree areas as the most severe. She stated that on 1/8/23 the resident's foot color changed a bit. Some areas of the skin were starting to peel around the edges, with about 30% of the right foot having those type skin issues. The 5th toe on the right foot was 100% affected by burns at that time, with skin peeling and encrusted. This went to between the 3rd and 4th toe with the webbing affected. The third toe was peeling at the top, and there was an open area between the 3rd and 4th toe. There were no plantar burns to either foot. On the left foot there was an open skin area on the great toe at approximately 75-80% and went from pink to a deep red. Near the arch there was a 2 cm blister that was intact. There was no erythema, swelling, or weeping noted to either foot at that time. It look like some epidermis was sloughing off. By 1/9/23 there was a 1 cm erythema area, and on the right foot there was a thin area in the center that turned whitish. Overall, the left foot was a darker red. Because the family had agreed the medical director would see the resident on Tuesday, 1/10/23, she made no further attempts to send the resident to the emergency department. 13. Review of the American Burn Association's Got Burned? When to Seek Medical Attention found at https://ameriburn.org/wp-content/uploads/2020/03/got-burned-1.pdf and retrieved on 1/13/23 showed medical attention should be sought when the burn is located on the face, ears, eye, hands, feet or genital area. Additional review showed if the burn is red, blistered, swollen and very painful, it may be a second degree burn. If the burn is whitish, charred or translucent, or the skin is peeling off, with minimal sensation in the area, it may be a third degree burn. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	14. Interview with DO #1 on 1/11/23 at 3:35 PM revealed she was on-call for the local emergency department and the facility from Friday the 6th through Monday the 9th of January 2023. She did not remember a call on 1/7/23 from the ED/RN, but did remember the call from the ED/RN on 1/8/23 concerning a family request for the resident be transferred to the emergency department related to the burns. She stated that she believed the ED/RN, who was wound care certified, could handle the resident's burns better than the staff at the hospital. DO #1 felt the resident would have been seen at the local emergency department and just sent back to the facility. She did not believe the resident's burns were that bad. She confirmed she called the resident's POA back on 1/8/23 promptly after she received the call from the ED/RN, and she told the POA the resident should not come to the local ED, that s/he was getting adequate care at the facility, and she had given physician orders concerning wound care. She stated that in her conversation with the POA, she mentioned the cold weather being an impediment to transfer related to comfort, and discussed whether the resident should be placed on comfort measures instead of aggressive treatment for the burn injuries. She felt the decision was professionally sound to have the resident remain at that facility instead of facilitating a transfer to the local emergency department. 15. Interview with the POA on 1/11/23 at 4:15 PM revealed [s/he] was not pleased with the 1/8/23 conversation with DO #1. The POA stated [s/he] expressed to DO #1 the desire for the resident to be transferred to the local ED for assessment, and stated DO #1 was resistant to having the resident transferred. The POA lost confidence in DO #1, and afterward, when ED/RN stated the difficulty of transferring the resident to a hospital further away without being transferred to the local ED first, the POA felt the only option left was to wait for the medical director to arrive and assess the resident. 16. Review of the nursing progress note dated 1/9/23 and timed at 8:15 PM showed Resident has tolerated the day with no issues. Dressings were changed to bilateral feet. When cleansed skin did slough off the toes. Tissue on both feet pink/red/left is a little darker around the toe. On the left foot it did bleed through the dressing and was reinforced. Resident was given tylenol throughout the day. 17. Interview with the ED/RN on 1/11/23 at 10:45 AM confirmed she had contacted DO #1 on 1/7/23 regarding request for transfer to the ED, and again on 1/8/23 regarding the family request to send the resident to the local ED. She further confirmed neither she nor other facility staff made any additional requests to send the resident to the local ED, and she felt she could have been more assertive concerning those requests. She relayed information to the medical director, but did not ask him to intervene with DO #1 regarding requests to transfer the resident to the local ED. 18. Review of the nursing progress note dated 1/10/23 and timed at 9:30 AM showed Late entry-Resident dressing bilateral had [strike] through bleeding noted. Dressings removed and a color change to discharge was noted. Burn area to top of l right foot is starting to turn a yellow color appears to look like eschar. There is with slight redness around the normal skin area's. The toes remained pink and red with skin continuing to slough. Right foot was cleansed with Normal saline and a thin cover of silvadine was placed- abd kerlex and then and ace wrap. The left foot also had a change in exudate color no odor to both. Burn is pink red in most places with slight darker area around the large toe. This foot was cleansed again and wrapped in the same manner. Further review of the medical record showed no evidence a physician was contacted about the state of the burns, and there was no attempt to send the resident to the emergency department. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	19. Observation on 1/10/23 at 3:50 PM in the treatment room (room [ROOM NUMBER]) showed the medical director, ED/RN, DNS, and POA with the resident for assessment of bilateral feet trauma/burns (first time a physician had assessed the resident's burns in person since the burns were sustained on 1/7/23). The DNS documented the wound measurements as the physician dictated to her at that time. The resident was asked about pain and appeared to be in no distress. The medical director and ED/RN removed the resident's dressings, and cleaned the wounds to both feet with saline and 4 by 4 sponges. The left foot had burns under and around the great toe, which had red, whitish, and yellowish areas. The measurements were 13 cm long by 5.5 cm across. At that time, the medical director told the POA he was going to contact a burn center. He stated that he felt the resident's feet must have been on the exposed heater fins and pipes for a while. The resident's right foot burns were then measured, and the burns extended from the 4th and 5th toes to two-thirds of the way back toward the heel. The measurements were 16.3 cm length by 11.3 cm across, with reddened, whitish, and yellowish areas. The wounds on both feet had areas that appeared dry and areas that appeared moist, with no obvious infection. The medical director stated at that time the wounds were high risk. 20. Interview with the medical director on 1/10/23 at 4:05 PM confirmed the resident should have been sent to the local emergency department on 1/7/23 at the time the resident sustained the burns, that parts of the burns were at least 3rd degree burns, and that he would start immediately contacting burn centers to have the resident transferred as soon as possible. He confirmed the process regarding transferring residents to the local emergency department would need to be reviewed and revised. 21. Review of the American Burn Association's Burn Center Referral Criteria found at http://ameriburn.org/wp-content/uploads/2017/05/burncenterreferralcriteria.pdf and retrieved on 1/13/23 showed second degree burns are partial thickness burns. The skin may be red, blistered, or swollen. The burns are very painful. Third degree burns are full thickness burns. They may appear whitish, charred or translucent, with no pin prick sensation in the burned area. 22. Review of progress notes dated 1/11/23 and timed 10:08 PM showed the resident was supposed to be transferred to a burn center in another state by helicopter, however, weather on 1/11/23 caused a delay. Review of a progress note dated 1/12/23 and timed 8:40 AM (5 days after the burns were sustained) showed Life flight arrived and report given to them. Resident was loaded on to gurney with no issues. 23. Review of an email sent by the POA to the State Survey Agency on 1/22/23 at 6:22 PM showed the resident underwent surgery for the burns on 1/20/23. The surgeon performed bilateral amputation of both feet. This left a few toes on each side. [The resident] is currently still in ICU [the intensive care unit] with both feet bandaged with a wound vac [vacuum] on the right foot and a skin graft on the left foot. On 1/11/23 at 6:03 PM the executive director was informed of an immediate jeopardy situation in the area of neglect related to the failure to provide ongoing assessment and interventions for a resident with significant burns to the feet bilaterally. The facility submitted an action plan which included the following immediate changes: a. Ongoing identification and assessment of acute changes in condition that require the physician to be notified in order to meet the resident's needs in a timely manner. Resident #1 was transferred to a higher level of care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. The initial audit for residents who had a change in condition was completed on 1/11/23. c. Education on the process was provided to licensed nurses on 1/12/23. d. A change in process that, if an attending physician refuses to provide the required transfer order, nursing staff will contact the medical director for that transfer order. The action plan was accepted on 1/13/23 at 12:10 PM. The implementation of the action plan was verified and immediacy was removed on 1/13/23 at 1:25 PM; however, deficient practice remained at a scope and severity of G.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 25745 Based on employee record review and staff interview, the facility failed to ensure the state nurse aide registry was checked prior to employment to ensure there were no findings listed for 2 of 4 sample CNAs (CNA #1, CNA #4) reviewed. The findings were: 1. Review of the employee record for CNA #1 showed a date of hire of 11/23/21. Review of the entire record showed no documentation to verify the State nurse aide registry was checked for findings. 2. Review of the employee record for CNA #4 showed a date of hire of 12/19/22. Review of the entire record showed no documentation to verify the State nurse aide registry was checked for findings. 3. Interview with the business office manager on 1/12/23 at 4:15 PM confirmed she had failed to ensure the State nurse aide registry was checked for CNA #1 and CNA #4.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on observation, medical record review, family and staff interview, water boiler temperature audits review, and review of an email update, the facility failed to ensure the resident environment remained free of accident hazards for 1 of 1 residents (#1) with burns received from the heat source in their room. This failure resulted in harm to resident #1, who sustained burns that required transport to a burn center, amputations and skin grafts. The facility implemented corrective actions prior to the survey. These actions were verified by the survey team and the facility was determined to be in compliance on 1/8/23. The findings were: Review of the 11/24/22 quarterly MDS assessment showed resident #1 had diagnoses which included diabetes mellitus, atrial fibrillation, coronary artery disease, hypertension, and non-Alzheimer's dementia. The assessment showed the resident had no pressure ulcer or other skin conditions at that time. The resident's brief interview for mental status could not be completed due to severe cognitive impairment, and s/he required the extensive assistance of one staff person for bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed). Review of the resident's care plan showed an 8/31/21 plan related to diabetes mellitus with an intervention to avoid exposure to extreme heat and cold. The following concerns were identified: 1. Interview with CNA #4 on 1/10/23 at 6:25 PM revealed she was working the morning of 1/7/23, and found the resident between 3:45 AM to 4 AM with the bed pushed from the wall and the resident's feet on the heater unit with the vent cover missing. The resident's feet were on the fins and pipes (the hot elements) within the heater unit. It was apparent that the feet were both burned in areas with some peeled skin and some blood, so she got the resident's feet away from the hot elements and onto the bed, and called for the nurse, who arrived promptly. The CNA had last checked on the resident during rounds at around 1:45 AM. The CNA said she had no experience with burns, but could tell the resident's feet were burned. 2. Review of the facility-documented water boiler temperatures from 12/5/22 to 1/7/23 showed the temperatures at the boiler were consistently 160 degrees F, and water from the boiler was utilized in the heating system throughout the facility. 3. Observations on 1/10/23 from 2:30 PM to 3:20 PM in all resident rooms and common areas, showed all heat vent covers were attached. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. Observation on 1/10/23 at 3:50 PM in the treatment room (room [ROOM NUMBER]) showed the medical director, administrator, DNS, and POA with the resident for assessment of bilateral feet trauma/burns The DNS documented the wound measurements as the physician dictated to her at that time. The resident was asked about pain and appeared to be in no distress. The medical director and administrator removed the resident's dressings, and cleaned the wounds to both feet with saline and 4 by 4 sponges. The left foot had burns under and around the great toe, which had red, whitish, and yellowish areas. The measurements were 13 cm long by 5.5 cm across. At that time, the medical director told the POA he was going to contact a burn center. He stated that he felt the resident's feet must have been on the exposed heater fins and pipes for a while. The resident's right foot burns were then measured, and the last 2 toes were involved to two-thirds the way back toward the heel. The measurements were 16.3 cm length by 11.3 cm across, with reddened, whitish, and yellowish areas. The wounds on both feet had areas that appeared dry and moistened, with no obvious infection. 5. Interview with the medical director on 1/10/23 at 4:05 PM confirmed the resident's burns had areas that were at least third degree burns. 6. Review of an email sent by the POA to the State Survey Agency on 1/22/23 at 6:22 PM showed the resident underwent surgery for the burns on 1/20/23. The surgeon performed bilateral amputation of both feet. This left a few toes on each side. He is currently still in ICU [the intensive care unit] with both feet bandaged with a wound vac [vacuum] on the right foot and a skin graft on the left foot. Review of the facility's 1/7/23 Self-initiated Immediate jeopardy .Abatement showed the following: Concern: 84 yr [year] old [gender], admitted [DATE] with dx of dementia, EPS [extra-pyramidal symptoms], a-fib [atrial fibrillation], DM [diabetes mellitus], ASHD [atherosclerotic heart disease], and IBS [irritable bowel syndrome]. Identified resident while sleeping in a low bed inadvertently extended [the resident's] legs out of the bed and displaced the floor board heater cover which left [the resident's] feet exposed to heat without the protection of the heater cover. Resident experienced second degree burns to the left great, second, and third toes and an area on left medial foot and blisters to right foot. 1. Resident assessed by RN for burns to bilateral feet. Physician notified and appropriate treatment order obtained and provided .Identified heater panel cover secured on 1/7/23 to prevent another occurrence. 2. Initial audit completed via Executive Director of floor heater panel covers throughout Center to assess for any others which may have the potential to be dislodged. Those that were identified as a concern were repaired starting on 1/7/23 and completed on 1/8/23. 3. Education provided to IDT [interdisciplinary team] regarding weekly audits of heater panel covers for secure placement as assigned. Ongoing audits by IDT related to assigned rooms to assess for secure placement of heater panel covers will be completed weekly times three months. Education provided to current staff to notify Executive Director immediately if they should observe an unsecured heater panel cover. (continued on next page)

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	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thermopolis Rehabilitation and Wellness	1210 Canyon Hills Rd Thermopolis, WY 82443

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. Initial ad-hoc QAPI held with Medical Director on 1/7/23 to discuss occurrence. Initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further discussion and recommendations. 5. Correction date: 1/8/23.

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	01/13/2023

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 47344 Based on review of the facility assessment, and staff interview, the facility failed to identify wound care services, wound care education, and wound care competencies in the facility assessment as required to ensure residents with wounds received appropriate care. There were 2 residents with wounds at the time of the survey. The findings were: Review of the facility assessment, last updated March 29, 2022 showed the following concerns: a. The review showed the assessment failed to identify and address services, education and competencies required in the area of wound care. b. Interview with ED/RN on 1/12/23 at 2:00 PM confirmed the facility assessment failed to identify and address wound care and she confirmed wound care should have been addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 25745 Based on review of transfer agreements and staff interview, the facility failed to ensure a written transfer agreement with at least one hospital was obtained. The findings were: Review of the facility's written agreements showed the facility had agreements with 2 skilled nursing facilities, and a local laboratory. The review showed there were no transfer agreements with any hospitals. Interview with the ED/RN on 1/17/23 at 9 AM confirmed the facility failed to ensure a written transfer agreement had been obtained with a hospital to meet the requirements.