Department of Health & Human Services Centers for Medicare & Medicaid Services

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2023		
NAME OF PROVIDER OR SUPPLIER Thermopolis Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few					

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 535051

If continuation sheet Page 1 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED			
	535051	B. Wing	03/10/2023			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
Thermopolis Rehabilitation and Wellness		1210 Canyon Hills Rd Thermopolis, WY 82443				
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 - Actual harm	d. Interview with the resident while at the hospital on 3/10/23 at 1:20 PM confirmed the Foley catheter had never been changed at the nursing home, and that s/he had been admitted last October.					
Residents Affected - Few	e. Review of the resident's care plan, undated, showed Foley catheter related to terminal condition of cirrhosis of liver with ascites and interventions included catheter changes as protocol.					
	f. Review of the physician orders fa	ailed to show any specific orders for ca	re of the Foley catheter.			
	g. Review of the facility standing orders showed catheter care to be as directed by nursing staff.					
	h. Interview with the interim administrator on 3/10/23 at 9 AM revealed the urinary catheter care in this instance was very poor care and did not meet facility expectations.					
	with diagnoses which included diab	2. Review of the admission MDS assessment dated [DATE] showed resident #2 was admitted to the facility with diagnoses which included diabetes mellitus, and anxiety disorder. Further review indicated the resident had a BIMS score of 15 of 15 indicating the resident was cognitively intact. The following concerns were dentified:				
	a. Review of the facility grievance log indicated on 2/15/23 the resident complained the former administrator of the facility had approached the resident in his/her room and wanted the resident to take a particular medication for his/her blood sugar. The resident refused and expressed concerns about the medication. The resident reported the former administrator then indicated to the resident if s/he did not want to work with the facility to fix their condition s/he would be kicked out and have to go someplace else.					
	b. Interview with resident #2 on 3/9/23 at 3 PM revealed the grievance was accurate and reiterated the occurrence. Further interview revealed the resident had been a lifelong diabetic and felt the condition was controlled with Humalog (insulin). The resident regarded the former administrator's statement as a threat, but felt safe at the facility since the former administrator was no longer working at the facility. The resident stated the former administrator had also called his/her parents and threatened them in the same manner.					
	c. Review of the facility's 2/23/23 incident report showed the former administrator refused to be interviewed for the facility's investigation of this incident, and her employment was terminated.					
	d. Interview with the interim administrator on 3/10/23 at 9 AM confirmed that verbal or mental abuse would not be tolerated and that was the expectation for all of their facilities.					
	Seclusion, Mistreatment, Misappro showed Each resident has the righ abuse .neglect .The center implem by staff . and .Neglect: Failure of the services to a resident that are neces Neglect occurs when the facility is:	I, Freedom from Abuse, Neglect, Corporpriation of Resident Property, and Explet to be free from abuse, including verbalents policies and processes so that reside Center, its employees or service processary to avoid physical harm, pain, meaware of, or should have been aware of fails to provide them to the resident(s), ess.	oitation updated October 2022, al, mental, sexual, or physical sidents are not subjected to abuse viders to provide goods and ental anguish, or emotional distress. of, goods or services that a			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few				