| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535051 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Thermopolis Rehabilitation and Wellness** | **1210 Canyon Hills Rd , Thermopolis, Wyoming, 82443** |

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| F0000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys 10/22/25 through 10/23/25. The survey was prompted by complaint intake #2624871.<br><br>The following common abbreviations are used throughout this document:<br><br>CNA: Certified Nurse Aide<br><br>DON: Director of Nursing<br><br>MDS: Minimum Data Set<br><br>mg: milligrams<br><br>RN: Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F0000 | | 11/25/2025 |
| F0580<br>SS = D | Notify of Changes (Injury/Decline/Room, etc.)<br><br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or | F0580 | Corrective Action: Resident #1 Dexcom sensor was immediately applied to the resident per physician order. Blood glucose levels were monitored manually until the Dexcom device was fully functional and verified. Resident #1 primary provider and responsible party were notified of the corrective action.<br><br>Identification:<br><br>Residents with orders for continuous glucose monitoring devices were reviewed to validate devices were in place and function as ordered. No other discrepancies were identified.<br><br>Systemic Changes: Licensed staff were re-educated on following physician orders and the importance of ensuring CGM devices are applied and functioning as ordered. Licensed staff were re-educated on timely provider notification of blood sugar levels outside parameters or per standing order. Licensed nursing staff Nursing staff were educated on notifying primary providers of new orders and changes after a resident returns from the hospital. | 10/25/2025 |

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 reverse for further 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 |
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| F0580<br>SS = D | Continued from page 1<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident<br><br>representative(s).<br><br>§483.10(g)(15)<br><br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure physician notification of a resident change in condition for 1 of 4 sample residents (#1) reviewed for a change of condition. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 9/24/25 showed resident #1 had a mental status that was not assessed and diagnoses which included diabetes mellitus and non-Alzheimer's dementia. The following concerns were identified:<br><br>a. Review of the medication administration record for September 2025 showed the resident received insulin | F0580 | Continued from page 1<br><br>Monitoring: DNS/Designee will perform a weekly audit of residents to CGM orders which will be ducted for four weeks, then monthly for three months, to validate compliance. DNS/Designee will perform and weekly audit of notification to primary physician of new orders when a resident returns from he hospital. Andy variance will be reported will be corrected and brought to QAPI. | |

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| F0580 SS = D | Continued from page 2<br>degludec, blood sugar check twice per day, Januvia 100 mg daily, and metformin 100 mg twice per day for diabetes mellitus which were all discontinued on 9/9/25.<br><br>b. Review of a progress dated 9/7/25 and timed 11:53 PM showed "Pt. [patient] observed slumped in recliner. Diaphoretic with AMS [altered mental status]. Unable to follow simple commands. VS [vital signs] 100F [Fahrenheit], 88 FSBS [fingerstick blood sugar], 99/47BP [blood pressure] 72BPM [beats per minute] NSR [normal sinus rhythm] 12 RR [respiratory rate] 90% RA [room air]. O2 [oxygen] NC [nasal cannula] applied. EMS [emergency medical services] notified for transport. Attempts were made to contact NPOA [power of attorney] and Charge Nurse to no result. Awaiting transport at 2358. Face sheet and MAR [medication administration record] given with verbal report to paramedic."<br><br>c. Review of a progress note dated 9/9/25 and timed 11:10 AM showed "New medication name, dose, frequency and diagnosis. Signs/symptoms of side effects.: Resident came back from hospital with new orders which include: discontinuing all sugar lowering agents both oral and subcutaneously. Nursing to d/c [discontinue] glucose checks. Nursing continues delirium precautions." There was no evidence the primary physician was notified of the discontinued medications and glucose monitoring.<br><br>d. Review of a progress note dated 9/17/25 and timed 2:14 AM showed the CNA reported the resident was exhibiting signs and symptoms of hyperglycemia which included polyuria, polydipsia, and polyphagia. The nurse obtained a blood glucose measurement via fingerstick which returned a result of 501. The note showed the facility would obtain a urine specimen to check for ketones and notify the oncoming nurse. Further review showed no evidence interventions were implemented or the physician was contacted.<br><br>e. Review of a progress note dated 9/17/25 and timed 9:12 AM showed the nurse obtained a blood glucose prior to breakfast which measured 494. The nurse contacted the physician's office to see if the physician would like to resume sliding scale insulin and received no new orders.<br><br>f. Review of a progress note dated 9/17/25 and timed 1:22 PM showed the physician called and wanted to get another blood sugar completed and start the resident on a low sliding scale. The blood glucose at that time was 567. | F0580 | | |

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| F0580 SS = D | Continued from page 3<br>g. Interview with RN #1 on 10/22/25 at 4:36 PM revealed on 9/17/25 when the resident had symptoms of hyperglycemia, he contacted the nurse coming on shift after him and she contacted the physician. The RN revealed the facility procedure was to send a fax to the physician; however, he felt the response needed to be sooner than they received from a fax. The RN revealed he did not call the physician because the facility did not have insulin he would have been able to administer to the resident.<br><br>h. Review of the emergency kit content list showed the available medications included insulin lispro, insulin NHP [intermediate acing insulin], insulin regular, insulin glargine, insulin detemir, and insulin aspart.<br><br>i. Interview with the administrator, DON, regional clinical director #1 and regional clinical director #2 on 10/23/25 at 9:37 AM revealed if a resident was displaying signs or symptoms or a change in condition, they would expect the nurse to assess the resident and monitor. If the condition worsened, they would expect the nurse to notify the physician. They revealed if a resident was experiencing elevated or low blood sugars, they would expect the physician to be notified per the physician's parameters and they would expect the nurse to call the physician and not send a fax.<br><br>j. Interview with the administrator and regional clinical director #1 on 10/23/25 at 11:32 AM confirmed the resident's medications and monitoring was discontinued following the hospital visit. Further they revealed notification of the physician would be based on nursing judgement if the resident did not have notification parameters.<br><br>k. Interview with the resident's physician on 10/24/25 at 9:42 AM revealed the resident had a history or high blood glucose levels and she would expect the facility to notify her if the blood glucose was greater than 400. She revealed she was not notified of the discontinuation of insulin and blood glucose monitoring when the resident returned from the hospital on 9/9/25 and she was not notified of the elevated blood glucose on 9/17/25. Further she revealed she would expect the facility to call and not fax and there was always an on-call physician during off hours.<br><br>2. Review of the facility policy titled "Hypoglycemia/Hyperglycemia Recommended Guidelines" last updated "August 2025" showed "...3. Recommended provider notification parameters are blood sugar < [less than] 70 or > [greater than] 350 per American Diabetic Association however, providers may have varied | F0580 | | |

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| F0580 SS = D | Continued from page 4<br>parameters for notification..." | F0580 | | |
| F0684 SS = D | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents receive quality of care and treatment to meet the resident's mental, physical, and psychosocial needs for 1 of 4 sample residents (#1) reviewed for diabetic treatment. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 9/24/25 showed resident #1 had a mental status that was not assessed and diagnoses which included diabetes mellitus and non-Alzheimer's dementia. The following concerns were identified:<br><br>a. Review of an admission physician note dated 6/17/25 showed the resident had type 2 diabetes mellitus and the assessment/plan included a glucose monitor to his/her left arm to preventfinger stick blood sugar monitoring 3 times per day.<br><br>b. Review of the medication administration record for September 2025 showed the resident received insulin degludec, blood sugar check twice per day, Januvia 100 mg daily, and metformin 100 mg twice per day for diabetes mellitus which were all discontinued on 9/9/25. Further review showed no evidence of a continuous glucose monitor.<br><br>c. Review of a progress dated 9/7/25 and timed 11:53 PM showed "Pt. [patient] observed slumped in recliner. Diaphoretic with AMS [altered mental status]. Unable to follow simple commands. VS [vital signs] 100F [Fahrenheit], 88 FSBS [fingerstick blood sugar], 99/47BP [blood pressure] 72BPM [beats per minute] NSR [normal sinus rhythm] 12 RR [respiratory rate] 90% RA [room air]. O2 [oxygen] NC [nasal cannula] applied. EMS [emergency medical services] notified for transport. | F0684 | !. Corrective Action for the Identified Resident:<br>Resident #1 Dexcom sensor was immediately applied per the physician order. Blood glucose levels were monitored manually until the Dexcom device was fully functional and verified. The primary physician was notified of the corrective action.<br><br>Identification. Residents with orders for continuous glucose monitoring (CGM) devices were reviewed to validate devices were in place and functioning as ordered. No other discrepancies were identified.<br><br>Systemic Changes:<br><br>Licensed nursing staff were reeducated on following physicians' orders, timely physician notification of blood sugar levels outside parameters or per standing orders and notifying primary providers of new orders and changes after residents return from hospital.<br><br>Monitoring: DNS/Designee will perform a weekly audit of residents with CGM orders which will be conducted for four weeks, then monthly for three months, to validate compliance.<br><br>DNS/Designee will perform weekly audit of notification to primary provider of new orders when a resident returns from the hospital. Any variance will be corrected and brought to QAPI. | 10/25/2025 |

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| F0684 SS = D | Continued from page 5<br>Attempts were made to contact NPOA [power of attorney] and Charge Nurse to no result. Awaiting transport at 2358. Face sheet and MAR [medication administration record] given with verbal report to paramedic."<br><br>d. Review of a progress note dated 9/9/25 and timed 11:10 AM showed "New medication name, dose, frequency and diagnosis. Signs/symptoms of side effects.: Resident came back from hospital with new orders which include: discontinuing all sugar lowering agents both oral and subcutaneously. Nursing to d/c [discontinue] glucose checks. Nursing continues delirium precautions." There was no evidence the primary physician was notified of the discontinued medications and glucose monitoring.<br><br>e. Review of a progress note dated 9/17/25 and timed 2:14 AM showed the CNA reported the resident was exhibiting signs and symptoms of hyperglycemia which included polyuria, polydipsia, and polyphagia. The nurse obtained a blood glucose measurement via fingerstick which returned a result of 501. The note showed the facility would obtain a urine specimen to check for ketones and notify the oncoming nurse. Further review showed no evidence interventions were implemented or the physician was contacted.<br><br>f. Review of a progress note dated 9/17/25 and timed 9:12 AM showed the nurse obtained a blood glucose prior to breakfast which measured 494. The nurse contacted the physician's office to see if the physician would like to resume sliding scale insulin and received no new orders.<br><br>g. Review of a progress note dated 9/17/25 and timed 1:22 PM showed the physician called and wanted to get another blood sugar completed and start the resident on a low sliding scale. The blood glucose at that time was 567.<br><br>h. Interview with RN #1 on 10/22/25 at 4:36 PM revealed on 9/17/25 when the resident had symptoms of hyperglycemia, he contacted the nurse coming on shift after him and she contacted the physician. The RN revealed the facility procedure was to send a fax to the physician; however, he felt the response needed to be sooner than they received from a fax. The RN revealed he did not call the physician because the facility did not have insulin he would have been able to administer to the resident.<br><br>i. Review of the emergency kit content list showed the available medications included insulin lispro, insulin NHP [intermediate acing insulin], insulin regular, | F0684 | | |

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| F0684 SS = D | Continued from page 6<br>insulin glargine, insulin detemir, and insulin aspart.<br><br>2. Interview with the administrator, DON, regional clinical director #1 and regional clinical director #2 on 10/23/25 at 9:37 AM revealed if a resident was displaying signs or symptoms or a change in condition, they would expect the nurse to assess the resident and monitor. If the condition worsened, they would expect the nurse to notify the physician. They revealed if a resident was experiencing elevated or low blood sugars, they would expect the physician to be notified per the physician's parameters and they would expect the nurse to call the physician and not send a fax.<br><br>3. Interview with the administrator and regional clinical director #1 on 10/23/25 at 11:32 AM confirmed the resident's medications and monitoring was discontinued following the hospital visit. Further they revealed notification of the physician would be based on nursing judgement if the resident did not have notification parameters.<br><br>4. Interview with the administrator and regional clinical director #1 on 10/23/25 at 12:10 PM revealed a continuous glucose monitor had not been implemented since admission.<br><br>5. Interview with the resident's physician on 10/24/25 at 9:42 AM revealed the resident had a history or high blood glucose levels and she would expect the facility to notify her if the blood glucose was greater than 400. She revealed she was not notified of the discontinuation of insulin and blood glucose monitoring when the resident returned from the hospital on 9/9/25 and she was not notified of the elevated blood glucose on 9/17/25.She revealed she would expect the facility to call and not fax and there was always an on-call physician during off hours. Further interview revealed she thought the resident was receiving blood glucose monitoring through a continuous glucose monitor.<br><br>6. Review of the facility policy titled "Hypoglycemia/Hyperglycemia Recommended Guidelines" last updated "August 2025" showed "...3. Recommended provider notification parameters are blood sugar < [less than] 70 or > [greater than] 350 per American Diabetic Association however, providers may have varied parameters for notification..." | F0684 | | |