| 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 11/20/2025 |
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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 recertification survey was conducted by Healthcare Licensing and Surveys from 11/17/25 through 11/20/25.<br><br>The following common abbreviations are used throughout this document:<br><br>BIMS: Brief Interview for Mental Status<br><br>CNA: Certified Nursing Assistant<br><br>RN: Registered Nurse<br><br>MDS: Minimum Data Set<br><br>NHA: Nursing Home Administrator<br><br>CDC: Centers for Disease Control and Prevention<br><br>OBRA: Omnibus Budget Reconciliation Act<br><br>OSHA: Occupational Health and Safety Administration<br><br>QAPI: Quality Assurance and Performance Improvement<br><br>MA-C: Certified Medication Aide<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F0000 | | 12/05/2025 |
| F0689<br>SS = D | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. | F0689 | Corrective Action: Staff member on shift during survey were re-educated on proper full body lift procedures and manufacturer guidelines.<br><br>Identification: All resident requiring mechanical lift transfers were audited to validate current transfer plans, equipment needs and care instructions are accurate and up to date.<br><br>Systemic Changes: The DNS/Designee re-educated licensed nursing staff on full body mechanical life use, manufacturer guidelines, and safe-transfer procedures by date of compliance. Staff members on PTO will be | 11/28/2025 |

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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| F0689 SS = D | Continued from page 1<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interview, medical record review, and manufacturer's instruction review, the facility failed to ensure appropriate use of mechanical lifts during 1 random observation of mechanical lift transfers for a sample resident #3. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 4/25/25 showed resident #3 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included heart failure, morbid obesity, anxiety disorder and post-traumatic stress disorder. Further review showed the resident was dependent on staff for chair/bed-to-chair transfer. Review of the care plan last revised on 8/15/2025 showed the resident had an ADL function decline related to reduced mobility due to his/her morbid obesity, weakness, and chronic health conditions, and used a mechanical lift for transfers. The following concerns were identified:<br><br>a. Observation on 11/19/25 at 3:20 PM showed two unidentified CNA's, and RN #1 entered the resident's room to assist him/her out of the wheelchair and into bed using a mechanical lift. Before the resident was transferred, a full body lift sling was placed under him/her, the Invacare Reliant 450 full body mechanical lift was placed over the resident, and the sling was attached to the mechanical lift. An unidentified CNA locked the caster brakes on the mechanical lift, lifted the resident out of the wheelchair, and unlocked the caster brakes as the resident was positioned over the bed. An unidentified CNA locked the caster brakes and then lowed the resident into the bed.<br><br>b. Interview with RN #1 on 11/20/25 at 1:51 PM confirmed the rear casters were locked when the resident was raised and lowered with the mechanical lift.<br><br>c. Interview with RN #2 on 11/20/25 at 10:23 AM revealed she would lock the rear casters of the mechanical lift while a resident was being raised, or lowered.<br><br>d. Interview with the DON on 11/20/25 at 11:29 AM revealed she thought it was ok to lock the casters during the transfer.<br><br>e. Review of the manufacturer's recommendations for the "Invacare Reliant 450" battery powered patient lift provided by the facility on 11/20/25 showed "...Lifting | F0689 | Continued from page 1<br>re-educated when they return to work.<br><br>Monitoring: The DNS/Designee will complete random mechanical lift observations twice weekly for four weeks, then weekly for eight weeks, followed by monthly checks thereafter. Findings will be documented and reviewed during QAPI. Any deviation from proper full body mechanical lift use will result in immediate corrective action and staff retraining. | |

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| F0689 SS = D | Continued from page 2<br>the Patient ...Warning ...Invacare does not recommend locking of the rear casters of the patient lift when lifting an individual. Doing so could cause the lift to tip and endanger the patient and assistants. Invacare does recommend that the rear casters be left unlocked during lifting procedures to allow the patient lift to stabilize itself when the patient is initially lifted from a chair, bed, or any stationary object..." | F0689 | | |
| F0760 SS = D | Residents are Free of Significant Med Errors<br><br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br><br>§483.45(f)(2) Residents are free of any significant medication errors.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review and staff interview, the facility failed to ensure residents were free from significant medication errors for 1 of 11 sampled residents (#40). The findings were:<br><br>1. Review of the 11/14/25 admission MDS assessment showed resident #40 had a BIMS of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included heart failure, atrial fibrillation. hypertension, presence of cardiac pacemaker, hypo-osmolality and hyponatremia. Further review showed the resident received a vasopressor medication, midodrine, which was administered based on blood pressure parameters. Review of the physician orders dated 11/14/25 showed the resident received midodrine 5 milligrams (mg) by mouth three times daily with meals for hypotension. The following concerns were identified.<br><br>a. Review of the physician orders dated 11/14/25 showed "May stop midodrine if blood pressure above 110."<br><br>b. Review of the medication administration record showed the resident's blood pressure prior to his/her scheduled noon dose of midodrine administration on 11/16/25 at 1:06 PM was 122/41. Further review showed the medication was administered by MA-C #1.<br><br>c. Interview with MA-C # 1 on 11/19/25 at 12:30 PM revealed if a resident's BP was higher than the ordered parameters to administer midodrine, she would hold the medication, document a progress note, and notify her supervisor or charge nurse. | F0760 | Corrective Action: The staff member who administered the medication outside the prescribed parameters was re-educated on the specific order and proper adherence to prescribed parameters.<br><br>The MAR was reviewed to validate the order, and parameters were clearly documented.<br><br>Identification: Vital sign documentation for all parameter-based medications was reviewed to validate correct assessments were being completed prior to administration.<br><br>Systemic Changes: Licensed nurses and medication aides were re-educated by the DNS on understanding and adhering to medication parameters, required assessments prior to medication administration, when to hold medication and notify the provider.<br><br>Monitor:<br><br>The DNS/designee will conduct, weekly audits of parameter-based medications 5x a week for 2 weeks, weekly audits 3x week for six week and monthly audit thereafter until compliance is achieved.<br><br>Any deviation from prescribed parameters will result in immediate corrective action and staff retraining. Audit results will be reviewed at monthly QA/QAPI meeting for continued monitoring. | 11/28/2025 |

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| F0760<br>SS = D | Continued from page 3<br>d. Interview with MA-C # 1 on 11/19/25 at 12:35 PM revealed that she contacted the physician on 11/16/25 to obtain parameter orders because there weren't any at the time of administration.<br><br>e. Review of medical records during the survey dates showed no evidence of the physician being contacted on 11/16/25 regarding the resident's blood pressure reading of 122/41.<br><br>f. Review of the resident's "weights and vitals" for 11/16/25 showed the resident had a blood pressure of 107/56 at 8:07 AM, 122/41 at 1:06 PM, and 101/41 at 4:42 PM. No other blood pressures were documented.<br><br>g. Review of a progress note provided by the regional clinical director at the survey, exit dated 11/19/25 and timed 1:30 PM showed the effective date was 11/16/25 at 1:28 PM. Further review showed "midodrine HCL Oral Tablet 5 mg Give 1 tablet by mouth with meals for hypotension [sic] BP [blood pressure] was taken prior to giving med and was low. Vital machine was used before getting vitals recorded. So after meal, BP showed that it was above the perimeter [sic] to give."<br><br>2. Interview with the DON on 11/20/25 at 10:30 AM revealed staff were expected not to administer midodrine if the blood pressure was outside of the ordering parameters. | F0760 | | |
| F0880<br>SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing | F0880 | Corrective Action: The staff member received immediate re-education on linen-handling and infection-control procedures.<br><br>Identification: A facility-wide observation of soiled-linen handling practices was completed across all shifts. All linen carts and soiled-linen bins were inspected to ensure appropriate bags, lids, and supplies were available.<br><br>Systemic Changes: Re-education was provided to nursing staff, housekeeping staff, on proper handling, containment, and transport of soiled linens.<br><br>Monitoring: The ICP/designee will perform random observations of soiled-linen handling 5 times per week for 4 weeks, then 1 time per week for 8 weeks, then 1 time monthly for 3 months. Non-compliance will result in immediate corrective action and re-education. Observation results will be reviewed during ASAP for ongoing oversight. | 11/28/2025 |

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| F0880 SS = D | Continued from page 4<br>services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F0880 | | |

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| F0880 SS = D | Continued from page 5<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interview, and review of policy and procedures, the facility failed to ensure effective infection prevention practices were implemented during one random observation of linen transportation. The findings were:<br><br>1. Observation on 11/17/2025 at 2:25 PM showed RN #3 walked down the East hall with unbagged soiled linen in her hands and transported them to the soiled laundry bin.<br><br>2. Interview with the infection prevention coordinator and NHA on 11/20/25 at 11:35 AM revealed soiled linen should be bagged before being removed from rooms and transported to the soiled laundry bin.<br><br>3. Review of the Centers for Disease Control and Prevention standards of practice titled "Laundry and Bedding", last revised 1/08/24, showed soiled laundry should be bagged prior to transporting to the soiled linen room.<br><br>4. Review of the facility policy titled "Infection Control Policies and Practices", last revised 5/30/23, showed "...6. The Executive Director or Governing Board, through the QAPI and infection control committees, have adopted our infection control policies and practices, as outlined herein, to reflect the Center's needs and operational requirements for preventing transmission of infections and communicable diseases as set forth in current OBRA, OSHA and CDC guidelines and recommendations..." | F0880 | | |