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 08/20/2026

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

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F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 8/17/26 through 8/20/26. The survey was prompted by complaint intakes 3091023, 3091054, and 3156079. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/12/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and standard of practice review, the facility failed to ensure residents received treatment and care in accordance with professional standards for 1 of 4 sample residents (#1) reviewed for a change of condition. This failure resulted in actual harm to resident #1.The findings were:	F0684	PLAN OF CORRECTION Preparation and execution of the response and plan of correction does not constitute an admission or agreement by 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 insubstantial 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. IDR Requested 1. Corrective Action for the Resident Affected Resident #1 is no longer a resident of the facility.	08/27/2026

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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F0684 SS = D	Continued from page 1 1. Review of the quarterly MDS dated 7/8/26 showed resident #1 had a mental status that was not assessed, and diagnoses which included ulcerative colitis, renal insufficiency, and anemia. The following concerns were identified: a. Review of a progress note dated 6/29/26 and timed 7:18 PM showed "Resident noted with coffee ground emesis and began reporting tightness in [his/her] chest. Lungs clear to auscultation. Heart rate and rhythm irregular. BS [bowel sounds] active x4 [times four] quadrants and tender upon palpation. VS [vital signs] obtained 139/79 BP [blood pressure], 130 HR [heart rate], 90% @ 2 LPM [liters per minute], 25 R [respirations], 99.5 T [temperature]. EMS [emergency medical services] called for transport to ED [emergency department] for eval and treat. Report called into [name] RN at [name of facility] ED. [Name] RN DON notified. [Name of family] notified. EMS into facility, report given, and care relinquished. Resident left facility on EMS stretcher at approx [sic] 1850." b. Review of a progress note dated 7/2/26 and timed 11:15 PM showed "Resident returned from hospital at approx [sic] 1805 [6:05 PM] with dx [diagnosis] of pleural effusion, hiatal hernia, and AKI [acute kidney injury]. Resident is AAOX4 [awake, alert, and oriented to person, place, time, and event]. Pleasant with good affect. Able to make needs known and follows commands appropriately. Speech clear, smile symmetrical. Eyes PERRLA [pupils equal, round, reactive to light, and accommodation], brisk. Hand grasps strong and equal. Lungs clear to auscultation. Denies chest pain, SOB [shortness of breath], and heart palpitations. On room air. Heart regular rate and rhythm. BS active x4 quadrants. Abdomen round, soft, tender to touch in lower quadrants. Denies N/V/D [nausea, vomiting, diarrhea]. Resident is continent of bowel, incontinent of bladder. Reports BM [bowel movement] today. Resident has order for full liquid diet and advance as tolerated. Medications taken whole with thin liquids. No chewing or swallowing deficits noted. Utilizing Walker for mobility. Edema noted to BLE [bilateral lower extremities]. Resident has scattered bruising to bilat [sic] arms from IV [intravenous] attempts/placement. Resident reports increased anxiety this shift. PRN [as needed] Xanax administered with effectiveness noted. Received PRN Tramadol for reports of generalized pain, effective. Resident is currently resting in bed with eyes closed. Respirations even and non labored. HOB up, bed locked in low position, call light within reach. Plan of care ongoing."	F0684	Continued from page 1 2. Identification of Other Residents Who May Be Affected. The DNS or designee conducted an audit of current residents to identify a change in condition during the previous 7 days to validate appropriate nursing assessment, and physician notifications are in place in accordance with professional standards. Any concerns identified during the audit will be addressed, including additional assessment, provider notification, implementation of appropriate treatment as ordered. 3. Systemic Changes to Prevent Recurrence The DNS or designee provided education to the licensed nursing staff regarding the facility's expectations for recognizing resident change in condition to include proper nursing assessment, resident monitoring, physician/family notification and documenting changes in resident condition. The DNS or designee will audit resident changes in condition weekly for 90 days to validate resident changes in conditions have a nursing assessment and timely physician notification. 4. Monitoring and Quality Assurance The DNS/designee will review the 24-Hour Report daily to monitor and validate timely notification of the provider and the resident’s family/POA for any identified change in condition. The DNS/designee will track and trend the results of these reviews and report the findings to the facility’s monthly QAPI Committee meeting. Monitoring will continue for 30 days or until substantial compliance has been achieved and sustained, as determined by the QAPI Committee. Any identified areas of non-compliance will be addressed promptly through education, coaching, and/or additional corrective action as indicated.	08/27/2026

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F0684 SS = D	Continued from page 2 c. Review of a progress note dated 7/3/26 and timed 10:53 PM showed "At approximately 2045 [8:45 PM] res had coffee ground emesis into trash can. I had tech sit by her bed until it resided." There was no evidence the primary physician was notified of the continued emesis after the resident returned from the hospital. d. Review of a progress note dated 7/4/26 and timed 1:50 AM showed "Res [resident] is in bed vomiting black fluids, HOB [head of bed] elevated to high fowlers, res is not c/o [complaining of] of pain at this time VS BP 152/94 HR n90 [sic] O2 90 R18 7/10 pain will continue to monitor." There was no evidence the primary physician was notified of the continued emesis after the resident returned from the hospital. e. Review of a progress note dated 7/4/26 and timed 9:30 AM showed "Resident continues to have nausea and vomiting. Had recent hospital stay and they did not find the source of the problem. EGD pland sre [sic] being spoke of. F/U [follow up] Monday." There was no evidence the primary physician was notified of the continued emesis after the resident returned from the hospital. f. Review of a progress note dated 7/6/26 and timed 2:26 PM showed "Resident informed what [sic] the nurse is going to contact the doctor for possible EGD [upper endoscopy]." g. Review of a progress note dated 7/8/26 and timed 10:45 AM showed "...[name of facility] clinic returned call this morning and discussed general surgery consult had been set up for tomorrow 7/9/26 at 3pm. Notified patient. Spoke with sister regarding appointment as well..." h. Review of a progress note dated 7/12/26 and timed 5:38 AM showed when the nurse went in to administer the resident's morning medication, the resident was unresponsive to verbal and tactile stimuli and had agonal breathing. The nurse called EMS and the resident was sent to the ER. i. Review of the hospital record dated 7/12/26 showed the resident had been brought in by	F0684		08/27/2026

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F0684 SS = D	Continued from page 3 ambulance, was hypotensive and unresponsive, and had been admitted to the hospital where s/he "peacefully passed" surrounded by family. j. Interview with the DON on 8/18/26 at 2:15 PM revealed if a resident had a "serious" change in condition, they would send the resident to the ER. She stated the nurses called her if they had a concern because they were unable to fax the doctor anymore. She stated they would call and leave a message, but the nurse at the clinic "got mad" if they called too much. Further interview revealed she followed up with the surgeon for an EGD consult. She stated she expected the nursing staff to document in a progress note if the primary care physician had been called. k. Interview with the regional clinical director on 8/18/26 at 2:30 PM revealed the facility protocol was to assess and monitor the resident, see what was on board, and if that did not work, to notify the provider. Further interview revealed they were only allowed to call the clinic on Tuesdays and Thursdays with concerns if the doctor's nurse was working, and if there was no one there, they left a voicemail on the "nurse line", hoped for a call back, and if they did not get one, they sent the resident to the ER. l. Interview with CNA #1 on 8/18/26 at 3:35 PM revealed the resident had been unable to keep anything down, had constantly vomited, and required frequent changing of bedding and clothing. Further interview revealed the "vomit looked like coffee grounds." m. Interview with LPN #1 on 8/18/26 at 4:15 PM revealed she recalled the resident had a "bout of emesis." Further interview confirmed she did not notify the physician. n. Interview with LPN #2 on 8/19/26 at 10:50 AM revealed the clinic wanted the staff to communicate on Tuesdays and Thursdays. Further interview revealed she received a phone call from the clinic that a general surgery consult had been scheduled for 7/9/26, and she wrote a "Communication with Provider" note to document the phone call. She reported communication with the clinic was "hard" and sometimes there was no response for a week or two.	F0684		08/27/2026

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F0684 SS = D	Continued from page 4 o. Interview with the NHA and regional clinical director on 8/19/26 at 11:01 AM revealed the resident had been back and forth to the hospital since April, and the resident's physician had treated the resident's nausea and vomiting with zofran. Further interview confirmed the resident's physician had not been contacted after the resident returned from the hospital on 7/2/26 and had coffee-ground and "black" emesis. p. Interview with the medical director on 8/20/26 at 3:08 PM revealed attending physicians were obligated to be on-call. Further interview revealed as the medical director, he was available as a "back-up" for staff to call. 2. According to Wolters Kluwer's “Lippincott Nursing Procedures”, ninth edition, copyright 2023, e-reader edition page 238 through 249: "...Assessment Technique... Document your assessment findings and the technique used to elicit each finding... Indicate the practitioner notified of any abnormal findings and the time of the notification. Document interventions required to treat those finding's as well as the patient's response to those interventions..." 3. According to Wolters Kluwer's “Lippincott Nursing Procedures”, ninth edition, copyright 2023, e-reader edition page 3027: "... Monitor the appearance of gastric drainage; report bloody or coffee-ground-color drainage, which may indicate bleeding..."	F0684		08/27/2026