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	10/23/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:1. Review of the quarterly MDS assessment dated [DATE] 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:a. 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. 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.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.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.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.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.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. 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.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. 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.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.2. Review of the facility policy titled Hypoglycemia/Hyperglycemia Recommended Guidelines last updated August 2025 showed, 3

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:1. Review of the quarterly MDS assessment dated [DATE] 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: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.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.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. 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.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.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.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.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.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. i. 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.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. 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.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.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