STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	4305 S Poplar Casper, WY 82601

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35081 Based on review of beneficiary protection notice information, staff interview, and policy and procedure review, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) and the Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage (SNF-ABN) forms were issued to the resident or the resident's representative in a timely manner for 1 of 3 sample residents (#76) reviewed. The findings were: 1. Review of the SNF Beneficiary Protection Notification Review form completed by the facility showed resident #76 had a Medicare Part A stay that started on 12/29/23 with the last covered day of Part A services on 3/12/24. The following concerns were identified: a. Review of the medical record showed no evidence a SNF ABN or NOMNC form was completed at the end of part A services. b. Interview with the business office manager on 6/12/24 at 5:52 PM revealed the resident should have been issued the notices; however, she was unable to find evidence the notices were issued. 2. Review of the policy titled Advance Beneficiary Notice provided by the facility on 6/13/24 showed .5 .a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), form CMS-10055 .c. A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO) .

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50665 Based on medical record review, and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) Level II was performed for 1 of 3 sample residents (#54) with a qualifying diagnosis. The findings were: 1. Review of the 3/27/24 quarterly MDS assessment showed resident #54 had a brief interview for mental status (BIMS) score of 8, which indicated moderate cognitive impairment, and had diagnoses which included anxiety disorder and post-traumatic stress disorder. The following concerns were identified: a. Review of a PASARR level I assessment completed on 8/3/23 showed the resident had post-traumatic stress disorder listed as primary psychiatric diagnosis. Further review showed the resident was indicated as categorically appropriate for convalescent care after acute hospital stay, not to exceed 120 days, an individual Level II determination will be required on the 120th day if client stay will be extended. Review of the resident's medical record showed no evidence a PASARR level II was completed. b. Interview with the DON on 6/11/24 at 4:58 PM revealed she was unable to find a PASARR level II assessment for the resident. Interview with the DON on 6/12/24 at 9:55 AM revealed social services were responsible for the completion of PASARR assessments; however, the facility did not have social services staff at that time. Further interview revealed the facility did not have a PASARR policy and the DON indicated the facility would follow CMS requirements.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents received assistance with activities of daily living for 1 of 4 sample residents (#36) reviewed during dining. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #36 had short-term memory and long-term memory impairment and had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and dysphagia. Further review showed the resident required set-up or clean-up assistance with eating. Review of the nutrition care plan last revised on 1/3/24 showed interventions which included staff provide cues and encouragement, physical assistance as needed. The following concerns were identified: a. Observation in the sunflower dining room on 6/10/24 beginning at 4:42 PM showed a dietary staff member was passing meal trays. At that time, an unidentified resident was attempting to reposition resident #36 to a table for dinner, where his/her meal was on the table. Resident #36 began piling items such as a drink, a napkin, and silverware on top of his/her plate. The resident had not consumed any food at that time. At 4:50 PM resident #36 began banging the table. Resident #55 and resident #61 attempted to provide verbal cues for resident #36 to eat his/her food. At 4:59 PM resident #61 went the table of resident #36, picked up a glass of fluid, and attempted to physically assist resident #36 to drink the fluid from the glass. Continued observation showed resident #61 picked up the pizza off resident #36's plate with his/her bare hands, and attempted to physically assist resident #36 to eat the pizza. The dietary staff member did not attempt to intervene. Resident #51 continued to try and assist resident #36 to eat until 5:05 PM when the dietary staff member obtained a grilled cheese sandwich and placed it on the table of resident #36. No physical assistance or verbal cues were provided by facility staff. At 5:06 PM resident #55 stood and walked to the table of resident #36, obtained a glass of fluid for resident #36, and attempted to assist resident #36 to drink the fluid. At 5:12 PM a staff member entered the dining room and administered medication to resident #36. No physical assistance or verbal cues for eating were provided to resident #36 by the staff member. At 5:15 PM the DON entered the dining room and sat near the fireplace. The DON remained in the dining room until 5:22 PM when she assisted resident #36 out of the dining room. No physical assistance or verbal cues for eating were provided to resident #36 by the DON. 2. Interview with the DON on 6/13/24 at 8:48 AM revealed staff should follow a resident's care plan for eating assistance. Further interview revealed it would not be appropriate for other residents to assist a resident to eat and the facility would not normally want residents touching another resident's food or attempting to assist another resident to eat or drink. 3. Interview with the infection preventionist on 6/13/24 at 11:02 AM revealed staff should not allow other residents to touch the food of another resident. She revealed residents' hands may be dirty and the food does not belong to them. 4. Review of the policy titled Activities of Daily Living provided by the facility on 6/13/24 showed .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of a policy titled Meal Supervision and Assistance provided by the facility on 6/13/24 showed .2. The facility will develop and implement an individualized care plan based the Resident Assessment Instrument (RAI) to address the resident's needs and goals, and to monitor the results of the planned interventions such as adequate supervision during meal time .15. If the resident refuses to eat, inform the supervisor .17. Encourage the resident to participate with his or her meal as much as possible .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37603 Based on observation, staff posting review, and staff interview, the facility failed to provide accurate data on the daily staff postings for a 2 week look back period. The findings were: 1. Observation of the posted nurse staffing on 6/10/24 showed the census was 74 and the LPNs and MA-Cs staffing data was combined on one line of the posting. 2. Review of the daily staff postings for a 2 week look back period from 6/11/24 showed the LPN and MA-Cs staffing data was combined on one line of the postings. 3. Interview with DON on 6/12/24 at 10:02 AM confirmed the daily staff postings did show the LPN/LVNs and MA-Cs were combined together. Further, she stated the LPN's/LVNs and MA-Cs should have been counted separately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 Based on observation, staff interview, policy and procedure, and manufactory recommendation review the facility failed to ensure expired medication were not available for use in 1 of 3 medication storage units (200 hall medication cart). The findings were: 1. Observation of the 200-hall medication cart on [DATE] at 10:35 AM with RN #1, showed one insulin Aspart flex pen 100 units per milliliter (u/ml) and one Basaglar (insulin glargine) injection 100 u/ml with no expiration dates. 2. Interview with the RN #1 on [DATE] at 10:35 AM confirmed the medication was for resident use, and revealed the insulin pens were to be dated when taken out of the refrigerator. 3. Interview with the DON on [DATE] at 12:52 PM revealed it was the facility expectation for staff to put an open date on the insulin pens. Further, she stated the nurse informed her the observed pens were not labeled with an open or expiration date. 4. Review of policy Medication Administration dated [DATE] showed .13. Identify expiration date. If expired, notify nurse manager . 5. Review of policy Insulin Pen dated [DATE] showed .2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed .and expiration date .9. Insulin pen should be disposed of after 28 days or according to manufacturer's recommendation . 6. Review of www.mynovoinsulin.com accessed on [DATE] showed the NovoLog pen was to be disposed of after 28 days even if there was insulin left in the pen or vial. 7. Review of basaglar.lilly.com accessed on [DATE] showed the Basaglar insulin pen was to be thrown away after 28 days. 50665

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50485 Based on observation, staff interview, manufacturer's instructions review, facility cleaning schedule review, facility policy and procedure review, and 2022 FDA Food Code review, the facility failed to ensure a sanitary environment in 1 out of 1 food preparation area (kitchen). The census was 74. The findings were: 1. Regarding unsanitary items in the kitchen preparation area: a. Observation on 6/10/24 at 1:40 PM during the initial brief tour showed a non-working hand washing sink in the dishwashing room. The drain pipe was disconnected and lying on the floor under the sink, with the water line still connected, and the ability to be turned on. Further observation showed a bucket of standing water under the sink to catch the water and two containers of hand sanitizer on the sink. b. Observation on 6/10/24 at 1:40 PM showed the floor under the dishwasher was dirty with grime, food particles, and hard water build-up on the floor and pipes. c. Observation on 6/12/24 at 10:07 AM showed the cleaning schedule was posted on the wall in the kitchen with no initials demonstrating cleaning as of 6/9/24. d. Interview with cook #1 on 6/12/24 at 10:07 AM revealed the faucet in the third section of the 3-compartment sink was broken and the hot water faucet was constantly running. Further interview revealed the facility was waiting on the faucet to be fixed. e. Interview with dietary aide #2 on 6/12/24 at 11:10 AM revealed the pipe under the handwash sink had been broken and the drain under the floor would need to be replaced. f. Interview with dietary aide #2 on 6/13/24 at 10:50 AM revealed the kitchen cleaning schedule was usually filled out and she was unsure why no one had done it so far that month. g. Review of the facility policy titled Sanitation Inspection provided by the facility administration on 6/13/24 showed .4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures and dishwasher temperatures daily. b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations . h. According to the 2022 FDA Food Code: .5-205.15 System Maintained in Good Repair. Improper repair or maintenance of any portion of the plumbing system may result in potential health hazards such as cross connections, backflow, or leakage. These conditions may result in the contamination of food, equipment, utensils, linens, or single service or single-use articles. Improper repair or maintenance may result in the creation of obnoxious odors or nuisances, and may also adversely affect the operation of ware washing equipment or other equipment which depends on sufficient volume and pressure to perform its intended functions . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regarding dishwasher temperature requirements: 2. Observation on 6/10/24 at 1:40 PM showed the facility used an Ecolab ES-4000 chemical sanitizing low temperature dishwasher. The temperature of the water was to be monitored at breakfast, lunch, and dinner. Review of the Ecolab dishwasher manufacturer's instructions showed the minimum temperature of the wash and rinse water was to be 120 degrees Fahrenheit (F), with a recommended temperature of 140 degrees F. Review of the dish room temperature log showed the temperature of the wash water should be at 120 degrees, and if not in range, to let management know. The following concerns were identified: a. Observation on 6/12/24 at 10:21 AM showed dietary aide #1 was washing and sanitizing dishes in the Ecolab ES4000 dishwasher. Interview at that time revealed the temperature of the dishwasher water started at 110 degrees F and might get up to 120 degrees F by the time all the dishes were washed. b. Observation on 6/13/24 at 10:04 AM showed dietary aide #2 tested the dishwasher temperature, obtained a temperature of 115 degrees F after running the dishwasher twice, and 120 degrees F after the third run of the dishwasher. Interview with the dietary aide #2 at that time revealed the facility maintenance staff and the technician from Ecolab were aware of the low temperatures. c. Review of the March 2024 dishwasher temperature log sheets showed the temperature of the wash water reached 120 degrees F, 1 out of 93 opportunities. d. Review of the May 2024 dishwasher temperature log sheets showed the temperature of the wash water reached 120 degrees F, 4 out of 93 opportunities. e. Review of the facility dishwasher temperature policy provided by the facility on 6/12/24 showed .2. Manufacturer's instructions shall be followed for machine washing and sanitizing .4. For low temperature dishwashers (chemical sanitization): a. The wash temperatures shall be 120 degrees F . f. According to the 2022 FDA Food Code 4-703.11 Hot Water and Chemical, .Efficacious sanitization depends on ware washing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization. When surface temperatures of utensils passing through ware washing machines using hot water for sanitizing do not reach the required 71 C (160 F), it is important to understand the factors affecting the decreased surface temperature. A comparison should be made between the machine manufacturer's operating instructions and the machine's actual wash and rinse temperatures and final rinse pressure. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in SS 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces .

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	535024	A. Building B. Wing	06/13/2024

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 35081 Based on observation and staff interview, the facility failed ensure a licensed administrator was responsible for the management of the facility. The census was 74. The findings were: 1. Interview with the facility administrator on 6/13/24 at 10:23 AM confirmed she did not live in the same town the facility was located. She revealed she communicated with the facility via email and phone calls and she confirmed she was unable to work on premise due to be employed with another agency in the town where she lived. Further interview confirmed her other employment requirements prevented her from being on-site at the facility and she revealed she had never been to the facility. 2. Observation between 6/10/24 and 6/13/24 showed the identified facility administrator was not present, on the premises, during the survey. Further observation throughout the survey showed the unlicensed administrator in training occupied the administrator's office and performing the management functions. 3. Interview with the DON and administrator in training on 6/10/24 at 1:41 PM revealed the facility administrator did not work on-site and had weekly calls with the facility. 4. Interview with the chief operating officer on 6/13/24 at 9:56 AM revealed the previous administrator went on leave on 5/20/24 and he was expected to return on 6/24/24 (6 weeks). She confirmed the current licensed administrator did not work on-site at the facility and revealed the she was employed at another agency in the town where she lived.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention guidelines were followed during meal service for 1 of 2 dining areas (sunflower). The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #36 had short-term memory and long-term memory impairment and had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and dysphagia. Further review showed the resident required set-up or clean-up assistance with eating. Review of the nutrition care plan last revised on 1/3/24 showed interventions which included staff provide cues and encouragement, physical assistance as needed. The following concerns were identified: a. Observation in the sunflower dining room on 6/10/24 beginning at 4:42 PM showed a dietary staff member was passing meal trays. At that time, an unidentified resident was attempting to reposition resident #36 to a table for dinner, where his/her meal was on the table. Resident #36 began piling items such as a drink, a napkin, and silverware on top of his/her plate. The resident had not consumed any food at that time. At 4:50 PM resident #36 began banging the table. Resident #55 and resident #61 attempted to provide verbal cues for resident #36 to eat his/her food. At 4:59 PM resident #61 went the table of resident #36, picked up a glass of fluid, and attempted to physically assist resident #36 to drink the fluid from the glass. Continued observation showed resident #61 picked up the pizza off resident #36's plate with his/her bare hands, and attempted to physically assist resident #36 to eat the pizza. The dietary staff member did not attempt to intervene. Resident #51 continued to try and assist resident #36 to eat until 5:05 PM when the dietary staff member obtained a grilled cheese sandwich and placed it on the table of resident #36. No physical assistance or verbal cues were provided by facility staff. At 5:06 PM resident #55 stood and walked to the table of resident #36, obtained a glass of fluid for resident #36, and attempted to assist resident #36 to drink the fluid. At 5:12 PM a staff member entered the dining room and administered medication to resident #36. No physical assistance or verbal cues for eating were provided to resident #36 by the staff member. At 5:15 PM the DON entered the dining room and sat near the fireplace. The DON remained in the dining room until 5:22 PM when she assisted resident #36 out of the dining room. No physical assistance or verbal cues for eating were provided to resident #36 by the DON. 2. Interview with the DON on 6/13/24 at 8:48 AM revealed staff should follow a resident's care plan for eating assistance. Further interview revealed it would not be appropriate for other residents to assist a resident to eat and the facility would not normally want residents touching another resident's food or attempting to assist another resident to eat or drink. 3. Interview with the infection preventionist on 6/13/24 at 11:02 AM revealed staff should not allow other residents to touch the food of another resident. She revealed residents' hands may be dirty and the food does not belong to them. 4. Review of the policy titled Activities of Daily Living provided by the facility on 6/13/24 showed .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 50485 Based on observation, staff interview, and review of the dishwasher temperature log sheets, manufacturer's instructions and the 2022 FDA Food code, the facility failed to ensure essential equipment was in safe operating condition in 1 of 1 food preparation areas (kitchen). The census was 74. The findings were: 1. Observation on 6/10/24 at 1:40 PM showed the facility used an Ecolab ES-4000 chemical sanitizing low temperature dishwasher. The temperature of the water was to be monitored at breakfast, lunch and dinner. Review of the Ecolab dishwasher manufacturer's instructions showed the minimum temperature of the wash and rinse water was to be 120 degrees Fahrenheit (F), with a recommended temperature of 140 degrees F. Review of the dish room temperature log shows that temperature of the wash water should be at 120 degrees F, and if not in range to let management know. The following concerns were identified: a. Observation on 6/12/24 at 10:21 AM showed dietary aide #1 washing and sanitizing dishes in the Ecolab ES4000 dishwasher. Dietary aide #1 revealed the temperature of the dishwasher water started at 110 degrees F and might get up to 120 degrees F by the time all the dishes were washed. b. Observation on 6/13/24 10:04 AM showed dietary aide #2 tested dishwasher water temperature, obtaining temperatures of 115 degrees F after running the dishwasher twice and 120 degrees F after the third run of the dishwasher. c. Interview on 6/13/24 at 10:04 AM with dietary aide #2 revealed facility maintenance and the technician from Ecolab were aware of the low water temperatures. d. Review of the March 2024 dishwasher temperature log sheets showed the temperature of the wash water reached 120 degrees F 1 out of 93 opportunities. e. Review of the May 2024 dishwasher temperature log sheets showed the temperature of the wash water reached 120 degrees F 4 out of 93 opportunities. 2. Review of the facility dishwasher temperature policy provided by the facility administration on 6/12/24 showed 2. Manufacturer's instructions shall be followed for machine washing and sanitizing. 4. For low temperature dishwashers (chemical sanitization): a. The wash temperatures shall be 120 degrees F. (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. According to the 2022 FDA Food code 4-703.11 Hot Water and Chemical, Efficacious sanitization depends on ware washing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization. When surface temperatures of utensils passing through ware washing machines using hot water for sanitizing do not reach the required 71 C (160 F), it is important to understand the factors affecting the decreased surface temperature. A comparison should be made between the machine manufacturer's operating instructions and the machine's actual wash and rinse temperatures and final rinse pressure. The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in SS 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces.