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	08/27/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on resident representative and staff interview, and medical record review, the facility failed to provide services to prevent, treat, and heal pressure ulcers for 1 of 4 sampled residents (#98) reviewed for pressure ulcers. This failure resulted in actual harm to resident #98 who developed pressure ulcers. The findings were: 1. Review of the admission MDS assessment, dated 5/18/25, showed resident (#98) had a BIMS score of 3 out of 15, which indicated s/he had severe cognitive impairment, and diagnoses which include type 2 diabetes mellitus, chronic kidney disease, coronary artery disease, and heart failure. Further review showed no wounds were present upon admission and the resident was at risk for pressure ulcers / injuries. The following concerns were identified: a. Review of a physician note, dated 5/15/25, showed the resident had a nickel sized unstageable pressure ulcer located on his/her right buttocks with orders for wound care and monitoring. Review of the medical record showed no treatment orders for wound care or monitoring.b. Review of the skilled nursing evaluation, dated 5/21/25 and timed 1:30 PM, showed the resident had an abraded area noted to the buttocks and cream was applied by RN #1. c. Review of the skilled nursing evaluation, dated 5/22/25 and timed 11:25 PM showed new pressure ulcers were present to the right and left heels, left medial calf, and an abrasion to the coccyx. Further review showed RN #1 notified the DON of the new ulcers, the DON observed pressure areas, and the DON planned to discuss the new ulcers with the certified wound nurse regarding treatment options. d. Review of a physician note dated 5/25/25 showed the resident had prevalon boots and orders to continue with wound care until completely healed. Review of the resident's medical record showed no evidence the prevalon boots, or wound care was added to the orders until 5/27/25. e. Interview with the resident's representative on 8/27/25 at 5:12 PM revealed the resident had been sent to the emergency room for another matter on 5/26/25 and the physician found concerning pressure ulcers on the resident's heels and buttocks. The resident did not return to the facility following the emergency room visit.f. Interview with the interim DON on 8/27/25 at 5:30 PM confirmed there were no wound care orders or documentation the facility was treating the resident's pressure ulcers prior to 5/27/25, after the resident had discharged .

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, staff interview, review of the facility Outbreak Investigation Tool, State Licensing incident database review, and policy and procedure review, the facility failed to implement a water management program to prevent, detect, and control the risk of water-borne pathogens, failed to report an outbreak of infectious disease involving 14 residents, and failed to ensure effective infection control practices were followed during 2 random observations. The census was 82. The findings were: 1. Observation on 8/24/25 at 5:08 PM showed resident #84 was in bed and his/her catheter bag was lying flat on the floor. Interview with CNA #1 at that time revealed the bed did not have a place to hang the bag so it was put on the floor. Observation on 8/25/25 at 9:25 AM showed resident #84 was in bed and his/her catheter bag was placed in a dignity bag and lying flat on the floor. Interview with the interim DON and the ADON on 8/26/25 at 3:14 PM confirmed catheter bags should not be placed directly on the floor. 2. Review of the Legionella Water Safety Program policy, dated 7/29/25 showed control measures had been identified and the facility was to Maintain logs for each control measure, including corrective actions taken for out-of-range values. Review data monthly to detect trends or deficiencies. Interview with the NHA on 8/27/25 at 2:15 PM revealed the water management plan for Legionella had not been implemented. 3. Observation on 8/24/25 at 1 PM showed several residents had been confined to their room due to a gastrointestinal outbreak with symptoms of nausea, diarrhea, and vomiting. Review of the Outbreak Investigation Tool showed the outbreak began on 8/22/25 and involved 14 residents. Review of the state licensing agency incident data base showed no evidence the facility had reported an infectious disease outbreak. Interview with the interim DON on 8/27/2025 at 3:41 PM revealed she was unaware of the requirement.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to include residents in the care planning process for 3 of 5 sample residents (#12, #30, #84) reviewed. The findings were: 1. Review of the 7/17/25 annual MDS assessment showed resident #12 was admitted to the facility on [DATE] and had a BIMS score of 15 out of 15 (cognitively intact). Further review showed the resident had a quarterly MDS assessment completed on 9/30/24, 12/31/24, and 4/2/25. The following concerns were identified: a. Interview with the resident on 8/24/25 at 3:47 PM revealed s/he did not recall being invited to a care conference meeting. b. Review of the resident's medical record showed the last documented care conference was held on 5/9/23. 2. Review of the quarterly MDS assessment showed resident #84 was admitted to the facility on [DATE] and had a BIMS score of 15 out of 15 (cognitively intact). The following concerns were identified: a. Interview with the resident on 8/25/25 at 9:27 AM revealed s/he had not been invited to a care conference meeting. b. Review of the resident's medical record showed the last documented care conference was held on 3/25/25. c. Review of the resident's care plan showed it was last revised on 6/30/25. 3. Review of the review of the comprehensive MDS assessment dated [DATE] showed resident #30 was initially admitted to the facility on [DATE], with the most recent reentry date of 8/26/23. Further review showed the resident had a BIMS score of 15 out of 15 (cognitively intact). The following concerns were identified: a. Interview with the resident on 8/25/25 at 9:50 AM revealed s/he recalled only being invited to one care conference meeting. b. Review of the resident's medical record showed the last 2 documented care conferences were held on 8/20/24 and 5/14/25. c. Review of the resident's care plan showed it was last revised on 7/24/25. 4. Interview with the interim DON on 8/26/25 at 5:42 PM revealed care conferences were held on a quarterly basis. Further interview revealed there was no evidence the residents participated in the planning process. 5. Review of the Care Planning-Resident Participation policy and procedure showed .The facility will (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a notice of transfer prior to a facility-initiated hospital transfer and provide written information on the bed-hold policy to the resident or the resident's representative for 3 of 5 sample residents (#6, #89, #94) reviewed for facility-initiated transfers. In addition, the facility failed to send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. The findings were: 1. Review of the medical record showed resident #6 was transferred to the hospital on 7/16/25. Further review showed no evidence the facility had issued a written transfer notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. 2. Review of the medical record showed resident #89 was transferred to the hospital on 7/18/25. Further review showed the Notice of Transfer/Discharge was not signed by the facility representative, and there was no verification of receipt of notice by the resident or responsible party. 3. Review of the medical record showed resident #94 was transferred to the hospital on 8/4/25. Further review showed no evidence the facility had issued a written transfer notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. In addition, the resident was transferred to the hospital on 8/24/25. The facility provided a written transfer notice to the surveyor; however, it was not signed by the administrator/administrative officer or the resident/resident's representative. 4. Interview with the NHA on 8/27/25 at 3:29 PM confirmed there was no record the notices were provided to the resident or resident representative or sent to the Ombudsmen. 5. Interview with the NHA on 8/27/25 at 3:29 PM confirmed no further documentation was available and was unable to locate documentation the Ombudsman had been notified of the transfers. 6. Review of the Bed Hold Notice policy showed It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave .1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies . 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record . 7. Review of the Transfer and Discharge (including AMA) policy showed .10. Emergency Transfer to Acute Care .g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation and staff interview, the facility failed to employ a sufficient number of staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services. The census was 82. The findings were: 1. Observation on 8/26/25 starting at 11:30 AM showed dietary aide #1 and cook #1 began the noon meal service by first preparing plates for the residents which required assistance with eating and were served in the Sunflower dining room. The meals were served on dinnerware with the exception of residents who required special utensils and plates. At 11:40 AM dietary aide #1 and cook #1 prepared room trays using dinnerware to serve the meal. Service to the main dining room began at 11:45 AM and approximately three quarters of the way through service the dinnerware was switched to black foam disposable plates. 2. Interview with cook #1 on 8/26/25 at 12:01 PM revealed the facility did not have enough clean dinnerware for all of the residents and had to switch to disposable plates. [NAME] #1 stated this happened more often than it should. 3. Interview with the dietary manager on 8/26/25 at 12:15 PM revealed if the facility had 2 dietary aides during the day, the aides were responsible for retrieving the room trays and washing the dishes before the next meal service; however, if the kitchen was short a dietary aide it was up to the CNAs to return the room trays to the kitchen. The dietary manager stated when the CNAs were responsible the room trays would trickle in and this did not always leave enough time to wash the dishes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 1 food preparation area. The census was 82. The findings were: 1. Observation on 8/24/25 at 1:10 PM showed an upright fan was blowing on a food preparation area located in front of the 3-compartment sink. On the food preparation counter was a cutting board and knife. The fan was darkened and soiled with debris. Further observation showed a rack used to store clean utensils and cookware was located directly behind the hooded gas cooking area. Between the grill/oven area and the storage rack were pipes that were visibly dirty and soiled.2. Observation on 8/26/25 at 9:04 AM showed the upright fan was blowing on the same food preparation area where dietary aide #1 was preparing individual syrup cups for residents. Interview with the dietary manager and cook #1 at that time confirmed the fan was not clean. [NAME] #1 immediately disconnected the fan and took it apart to clean it. The area behind the grill/oven remained the same.3. Interview with the dietary manager on 8/26/25 at 12:15 PM confirmed the area behind the grill/oven area was not clean and was not included on the cleaning schedule.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of policy and procedures, the facility failed to have a system in place to maintain documentation residents were provided education regarding the benefits and potential side effects of the COVID-19 vaccination and documentation of the consent or refusal of the immunization for 4 of 4 sample residents (#9, #10, #59, #84) reviewed for immunizations. The findings were: 1. Review of the 7/28/25 quarterly MDS assessment for resident #9 showed s/he was admitted to the facility on [DATE] and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 2. Review of the 8/8/25 quarterly MDS assessment for resident #10 showed s/he was admitted to the facility on [DATE] and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 3. Review of the 8/8/25 annual MDS assessment for resident #59 showed s/he was admitted to the facility on [DATE] and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 4. Review of the 6/22/25 quarterly MDS assessment fore resident #84 showed s/he was admitted to the facility on [DATE] and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 5. Interview with the interim DON and ADON on 8/26/25 at 3:14 PM confirmed no further documentation was available. 6. Review of the Coronavirus Disease (COVID-19) - Vaccination of Residents policy showed Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. 1. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. 2. The resident (or resident representative) can accept or refuse a COVID-19 vaccine and can change his/her decision. 3. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee .6. Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine .10. Residents must sign a consent to vaccinate form prior to receiving the vaccine. The form is provided to the resident in a language and format understood by the resident or representative

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 the advanced directive was formulated and accurate for 2 of 28 sample residents (#84, #93) reviewed. The findings were: 1. Review of the electronic medical record (EMR) showed resident #84 was listed as do not resuscitate (DNR). Further review of the medical record showed no evidence the resident had signed and dated an advance directive. Interview with the interim DON and MDS coordinator on [DATE] at 5:37 PM confirmed there was no evidence the resident had elected a DNR status. 2. Review of the EMR showed resident #93 was listed as a full code status. Review of a cardiopulmonary resuscitation (CPR) designation form provided by the interim DON on [DATE] at 4:48 PM was initialed No, do not administer CPR and signed and dated by the resident on [DATE]. Interview with the interim DON on [DATE] at 4:48 PM confirmed the EHR did not match the most recent election of no CPR. 3. Review of the Advance Directive policy showed . 7. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 2 of 5 residents (#9, #20) reviewed for unnecessary medications. The findings were: 1. Review of the 3/10/25 quarterly MDS assessment showed resident #9 was admitted to the facility on [DATE] and had a diagnosis of schizophrenia. The resident was coded as receiving antipsychotic, antianxiety, and antidepressant medications during the 7-day look-back period. The last attempted gradual dose reduction (GDR) was documented as occurring on 12/31/24. The following concerns were identified: a. Review of the 8/24/25 Psychotropic Medication Utilization Report showed the resident was prescribed quetiapine fumarate (antipsychotic) and buspirone hydrochloride (an antianxiety medication), for paranoid schizophrenia with the last risk-benefit statement completed on 9/17/24; however, the facility was unable to locate the risk-benefit statement signed by the resident's physician or documentation to support the 12/31/24 GDR as noted on the 3/10/25 quarterly MDS assessment. b. Review of the physician orders showed the resident was prescribed 1 milligram (mg) of lorazepam (an antianxiety medication) every 8 hours as needed (PRN) on 8/1/25 for comfort focused care; however, no stop date was indicated. Review of the August 2025 medication administration record showed the resident had not been administered a PRN dose of lorazepam during the month. c. Interview with the interim DON on 8/27/25 at 12:56 PM confirmed the physician order for PRN lorazepam did not have a stop date. In addition, the interim DON revealed she was currently working on organizing the psychotropic medication review process. An additional interview with the interim DON at 3:15 PM confirmed the GDR documentation for resident #9 could not be located. 2. Review of the 6/26/25 quarterly MDS assessment showed resident #98 was admitted to the facility on [DATE] and had a diagnosis of depression. The resident was coded as receiving antipsychotics and antidepressants during the 7-day look-back period. The MDS showed no GDR was attempted or documented as being clinically contraindicated. The following concerns were identified: a. Review of the physician orders showed that the resident was prescribed 100 mg of Sertraline daily for depression on 1/23/24. b. Review of the 10/28/24 Medication Regimen Review, signed by the physician, showed that no reduction of Sertraline was ordered at that time, and no clinical rationale was documented. c. Interview with the interim DON on 8/27/25 at 11:30 AM confirmed that no GDR was attempted and no rationale was documented for the resident.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the MDS RAI manual, the facility failed to ensure a significant change MDS assessment was completed for 1 of 28 sample residents (#10). The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #10 had a BIMS score of 0 out of 15 which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain injury, alcoholic cirrhosis of the liver, non-Alzheimer's dementia, and depression. Further review showed the resident was coded as being on hospice care. The following concerns were identified: a. Review of the resident's medical record showed a Discharge Summary from hospice with a discharge effective date of 5/9/25 due to lack of decline. b. Interview with the interim DON on 8/26/25 at 5:53 PM confirmed the resident was discharged from hospice on 5/2/25 and revealed the facility was not notified of the discharge by hospice until 7/7/25. c. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User Manual version 1.19.11 last revised October 2024 showed .An SCSA (Significant Change in Status Assessment) is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [Assessment Reference Date] must be within 14 days from one of the following: 10 the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 20 the expiration date of the certification of terminal illness; or 30 the date of the physician's or medical director's order stating the resident is no longer terminally ill .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review, staff interview, and review of the MDS RAI manual, the facility failed to ensure MDS assessments were accurate for 3 of 28 sample residents (#10, #12, #55). The findings were: 1. Review of the 2/9/22 Wyoming PASRR (pre-admission screening and resident review) Level II Determination Summary Report showed resident #12 had psychiatric diagnoses which included bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, and sleep terror. Further review showed the resident met the state definition of mental illness. The following concerns were identified: a. Review of the 7/1/25 annual MDS assessment showed section A1500 was marked no to the question if the resident was currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability. b. Interview on 8/26/25 at 2:38 PM with the MDS coordinator confirmed section A1500 was marked inaccurately. 2. Review of the 4/18/25 annual MDS assessment for resident #55 showed section GG (used to assess functional abilities and goals) was marked as not assessed. Interview on 8/26/25 at 2:38 PM with the MDS coordinator revealed the facility did not have staff available at that time to perform the assessment so section GG was dashed out. 3. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual version 1.19.11 last revised October 2024 showed .A1500: Preadmission Screening and Resident Review (PASRR) .code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1520, Level II Preadmission Screening and Resident Review (PASRR) Conditions. Section GG of the RAI manual showed the intent of this section included items focused on prior function, admission and discharge performance, discharge goals, performance throughout a resident's stay, mobility device use, and range of motion. Functional status was assessed based on the resident's need for assistance when performing self-care and mobility activities.

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	535024	A. Building B. Wing	08/27/2025

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure an environment was free from accident hazards for 2 of 3 residents (#7, #9) reviewed for smoking. The findings were:1. Review of the quarterly MDS assessment, dated 7/29/25, showed resident #7 had a BIMS score of 14 out of 15 (cognitively intact). The following concerns were identified:a. Observation on 8/25/25 at 3:59 PM showed the resident smoked in the courtyard during the scheduled smoking time.b. Review of the resident's medical record showed the last safe smoking evaluation was dated 3/10/25. Review of the resident's care plan, last updated 6/12/25, did not address smoking.2. Review of the 12/8/24 annual MDS assessment for resident #9 showed s/he was admitted to the facility on [DATE], had a BIMS score of 13 out of 15 (cognitively intact), and had diagnoses which included schizophrenia, respiratory failure, and COPD (chronic obstructive pulmonary disease). Review of the resident's care plan, dated 3/31/23, showed the resident was a smoker/uses tobacco products and was to be reevaluated via safe smoking evaluation quarterly and as needed. Review of the Resident Smoking policy showed .6. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. 7. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated .The following concerns were identified:a. Review of the resident's medical record showed the last documented Smoking and Safety evaluation was completed on 1/28/25.3. Interview with the interim DON and MDS coordinator on 8/26/25 at 5:43 PM confirmed there was no additional documentation available and smoking should be addressed in the care plan and assessed quarterly. 4. Review of the policy and procedure titled Resident Smoking showed .8. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy and procedure review, the facility failed to ensure residents with mental disorders received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 3 sample residents (#30) reviewed for behavioral and emotional needs. The findings were: 1. Review of the comprehensive MDS assessment dated [DATE] showed resident #30 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included bipolar disorder, other specified depressive episodes, other mixed anxiety disorders, cognitive communication deficit, and drug induced subacute dyskinesia. Review of the 5/18/25 quarterly MDS assessment showed the resident exhibited physical behavioral symptoms directed toward others 1 to 3 days of the 7-day look-back period, verbal behavioral symptoms directed at others 1 to 3 days of the 7-day look-back period, and rejection of evaluation or care 1 to 3 days of the 7-day look-back period. The following concerns were identified: a. Review of the resident's medical record showed a Wyoming PASRR (Preadmission Screening and Resident Review) Level II determination was completed on 3/15/21. Psychiatric diagnoses on the PASRR Level II included other mixed anxiety disorders, other specified depressive disorders, paranoid schizophrenia and bipolar disorder. Recommendations from the PASRR included supportive counseling from nursing facility staff and a minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan. Behaviors on the care plan showed the resident cursed and yelled at others, called his/her physician and other organizations up to 8 times per day, and had a history of false accusations.b. Review of the resident's entire medical record showed no evidence a psychological evaluation had been completed. c. Review of the resident's care plan showed intervention recommendations through PASRR II is the following: Family involvement in the clients care if available, Psychotropic medication monitoring, Educations regarding medication compliance and/or side effects, supportive counseling from NF [nursing facility] staff, Psychiatric records to clarify history and Minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan. Date initiated: 03/15/2021. Further review showed resident behaviors included calling his/her physician and other organizations up to 8 times per day, agitation and restlessness, refusal of cares, and yelling and cursing at others.d. Interview with the ombudsman on 8/25/25 at 3:55 PM revealed the resident frequently called, sometimes several times a day, and yelled and cussed at her. She reported she had asked the social services director to look into counseling for the resident but she did not hear back from him regarding that request.e. Interview with the interim DON on 8/27/25 at 9:54 AM revealed the resident did not receive counseling services, and the resident's physician talks with [him/her] weekly but does not document it. Further interview confirmed the resident had not received a yearly psychiatric evaluation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the interim DON's pharmacist monthly medication review binder, the facility failed to have a system in place to ensure the pharmacist's monthly medication reviews and recommendations were acted upon and documented in the resident's record for 1 of 5 sample residents (#9) reviewed for unnecessary medications. The findings were: Review of the 3/10/25 quarterly MDS assessment showed resident #9 was admitted to the facility on [DATE] and had a diagnosis of schizophrenia. The resident was coded as receiving antipsychotic, antianxiety, and antidepressant medications during the 7-day look-back period. Review of the resident's medical record and the interim DON's pharmacist monthly medication review binder showed no evidence the pharmacist had performed a monthly medication review which included any irregularities or recommendations for March, April, May, or June of 2025. Interview with the interim DON on 8/27/25 at 12:56 PM revealed she was in the process obtaining the missing documentation and updating the binder.

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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. Based on observation, staff interview, and manufacture instructions, the facility failed to label medications with the date opened in 1 of 4 medication storage areas (400 hall medication cart). The findings were: 1. Observation of the 400 hall medication cart on 8/26/25 at 12:07 PM showed a Lantus vial which was opened and undated. Review of the manufacturer's instructions titled Patient Medication Information - Lantus Vial last revised 12/1/21 showed opened insulin vials must be discarded after 28 days of opening. 2. Interview with RMA #1 on 8/26/25 at 12:07 PM revealed staff were responsible for labeling multidose vials of medications to indicate the date the medication was opened.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policies, the facility failed to have a system in place to maintain documentation residents were provided education regarding the benefits and potential side effects of the pneumococcal and influenza vaccines and documentation of the consent or refusal of the immunization for 1 of 4 sample residents (#59) reviewed for immunizations. The findings were: 1. Review of the 8/8/25 annual MDS assessment showed resident #59 was admitted to the facility on [DATE]. Further review of the MDS assessment showed the resident was offered and had declined the influenza and pneumococcal vaccines. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 2. Interview with the interim DON and ADON on 8/26/25 at 3:14 PM confirmed no further documentation was available. 3. Review of the Influenza Vaccine policy showed 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized .4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine .Provision of such education shall be documented in the resident's/employee's medical record. 5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record. 6. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. 4. Review of the Pneumococcal Vaccine policy showed 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series .3. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine .Provision of such education is documented in the resident's medical record .5. Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of refusal of the pneumococcal vaccination. 6. For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record .

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) were issued correctly for 2 of 3 sample residents (#13, #32). The findings were: 1. Review of the NOMNC/ABN for resident #13 indicated the last covered day for Medicare Part A services was 2/7/25. The following concerns were identified:a. Review of the NOMNC form showed a written note of Verbal received by [resident #13's representative] and the form was signed by the social services director on 2/4/25.b. Review of the SNF ABN form provided by the facility for resident #13 showed resident #32's name was at the top of the form. The form showed Medicare may not pay for physical therapy/occupational therapy following discharge from Medicare Part A services; however, the reason Medicare may not pay or the estimated cost was not included on the form. The form showed a written note of Verbal received by [resident #13's representative] and the form was signed by the social services director on 2/4/25.2. Review of the SNF ABN form for resident #32 indicated the last covered day for Medicare Part A services was 4/14/25. The form showed Medicare may not pay for Skilled nursing and skilled therapy; however, the reason Medicare may not pay or the estimated cost was not included on the form. 3. Interview with the interim DON and MDS coordinator on 8/26/25 at 5:37 PM confirmed the NOMNC and ABN forms were inaccurate.4. Review of the Medicare Advanced Beneficiary Notice policy showed Residents are informed in advance when changes will occur to their bills .1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled services(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice .to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered not medically reasonable and necessary, or custodial. b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility. 2. If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage .to the resident at least two calendar days before Medicare covered services end (for coverage reasons). a. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination .