STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rawlins Snf Operations LLC	542 16th St Rawlins, WY 82301

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative, hospital staff and staff interview the facility failed to ensure a resident was allowed to return following a transfer to an acute care setting for 1 of 3 sample residents (#1) reviewed for discharge. The findings were: 1. Review of the medical record for resident #1 showed the resident was admitted to the facility on [DATE]. Review of the admission MDS assessment dated [DATE] showed resident #1 was unable to complete a BIMS assessment, had severely impaired cognitive skills for daily decision making, and diagnoses which included non-Alzheimer's dementia, Pick's disease, other frontotemporal neurocognitive disorder, and aphasia. Further review of the medical record showed resident #1 had behavioral issues, which included wandering through the hallways and other resident rooms, defecating and urinating in the hallway, and physical aggression toward other residents and staff. The following concerns were identified: a. Review of a progress note dated 4/1/25 and timed 1:35 PM showed Late entry: While RN was completing resident's admission with [his/her] sister/POA, [name], she stated that resident has regressed quite a bit since [his/her] last stay here. She reported [s/he] was voiding and defecating in inappropriate places, often hypersexual, aggressive, and has not been bathed in 4 months due to her not wanting to fight with [him/her] to take a shower. RN reported this to [name], SSD, and [name], ED, as I felt as if these things were concerning with accepting this admission. This RN witnessed [SSD] enter the resident's room and tell [sister] that we will take resident on a trial basis, however if resident proves too much for our staff to handle or it doesn't work out we will send out referrals to get [him/her] to a more secure locked unit, however she would need to come pick [him/her] up. b. Review of a progress note dated 4/7/25 and timed 7:11 PM showed Spoke with sister [name] at length regarding placement to a locked unit. We have not been successful at this time. She is distraught and afraid [s/he] will be placed far away. She is teary and concerned. We assured her that we will do everything we can for [him/her] and her. She gave some insight into some activities [s/he] does enjoy . c. Review of a progress note dated 5/28/25 and timed 2:36 PM showed referrals were sent to 10 care centers by the SSD. (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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