STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK REHABILITATION CENTER	**1445 UINTA DRIVE GREEN RIVER, WY 82935**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 5/22/19 to 5/23/19. The survey was prompted by complaint intake WY00002833. The following common abbreviations are used through this document: CNA; Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		6/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2019

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.

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F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of facility incident reports, the facility failed to develop a care plan to ensure safety for 1 of 1 sample resident (#1) who reported an allegation which occurred outside the facility. The findings were: Review of an incident report dated 5/16/19 showed resident #1 reported an incident, which occurred outside the facility, and involved an individual who visited the resident at the facility. The incident resulted in a potential safety risk for the resident during visits with the identified individual. Interview with resident #1 on 5/22/19 at 4:10 PM revealed the resident did not feel safe leaving the facility; however, the resident wanted to continue to have the individual visit him/her at	F 656	F. Tag. F656 Immediate corrective action: Audit of incidents of the last six months conducted. Resident #1 care plan review and appropriate interventions added. How the facility will identify other residents having the potential to be affected: Potential to affect any resident. Measures put in place or system correction in this area include: Monthly audits of incidents and care plans that coordinate for appropriate updates/reviews. Utilize a Resident Incident Worksheet. Signature sheets to be completed when educating staff	

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F 656	Continued From page 2 the facility. The following concerns were identified: a. Interview with CNA #1 on 5/22/19 at 4:52 PM revealed the CNA was unsure if the identified individual was allowed to visit the resident at the facility. b. Interview with LPN #1 on 5/22/19 at 4:56 PM revealed she was educated by the DON that if the individual visited the facility, staff were to monitor the interaction for any inappropriate behaviors from the visitor and visit with the resident following the interaction to assess for fear or other concerns. Further interview revealed the individual "usually" only visited for "about 5 minutes." c. Interview with CNA #2 on 5/22/19 at 4:58 PM revealed the CNA thought the individual was not allowed to visit the resident. d. Interview with CNA #3 on 5/23/19 at 9:35 AM revealed staff were to notify the nurse when the individual visited and staff were expected to monitor the resident for safety. e. Interview with LPN #2 on 5/23/19 at 9:39 AM revealed the nurses were trained to monitor the resident for safety when the individual visited and to encourage the resident to visit in areas where s/he was not alone with the individual. f. Interview with CNA #4 on 5/23/19 at 9:41 AM revealed staff were to notify the nurse if the resident had visitors due to safety concerns. g. Interview with CNA #5 on 5/23/19 at 9:43 AM revealed staff were to monitor the resident for safety if the individual visited the resident. h. Interview with LPN #3 on 5/23/19 at 9:45 AM revealed staff were to monitor interactions between the resident and the individual to ensure the resident's safety. Further interview revealed staff were to intervene if there was any noted agitation.	F 656	members of event/interventions. Who will monitor the new system: Director of Nursing and/or Social Service Director How frequently will we monitor: Monthly How will we incorporate the new system into our QAPI system: Monthly audits of incidents and follow-up components including care plan updates and staff education.	

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F 656	Continued From page 3 i. Review of the care plan last revised on 3/27/19 showed no evidence a care plan was developed to ensure the resident was safe when the individual visited the facility. j. Interview with the DON on 5/22/19 at 5:08 PM revealed the facility educated nurses to monitor the interactions between the individual and the resident from a distance and notify local law enforcement if anything inappropriate occurred. The DON revealed there was no documentation of the education and the facility did not care plan the interventions.	F 656		