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 _____	C 05/18/2022

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 5/17/22 to 5/18/22. The survey was prompted by complaint intake WY000003408. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: BIMS - Brief Interview for Mental Status CNA - Certified Nurse Aide DON - Director of Nursing MDS - Minimum Data Set RN - Registered Nurse SBAR - Situation, Background, Assessment, Recommendation	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: DHA — (X6) DATE: 7/15/22

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident interview and staff interview, the facility failed to ensure residents were free from physical abuse for 1 of 5 residents (#2) reviewed for behavioral symptoms. This failure resulted in harm to resident #2, who was punched in the face by another resident, and sustained bruises to the face and wrist. The findings were: 1. Review of the 5/4/22 quarterly MDS assessment for resident #1 showed the resident was admitted on 9/3/20 with diagnoses which included unspecified dementia with behavioral disturbance. The resident had severe cognitive impairment with a BIMS score of 4 out of 15. The resident also had physical and verbal behavioral symptoms on 1 to 3 days during the look back period. Review of the 4/21/22 annual MDS assessment for resident #2 showed the resident had diagnoses which included dementia and anxiety. The resident had a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Review of the Medication Regimen Review for resident #1, dated 12/21/21, showed a recommendation signed by the physician that read, "...continue the prn Haldol [an antipsychotic medication], still necessary to prevent harm to others..." Review of the quarterly Psychotropic Medication Management Review dated 3/15/22 showed the following recommendations: "...dangerous behaviors less frequent only 1 time	F 600	F600 Correction: DON or designee On or before 5/20/22 the ~~facility~~ will review behavioral symptoms for residents #1 and #2 to ensure that they are safe and free from abuse. Identification: DON or designee On or before 5/20/22, the ~~facility~~ will review all residents with aggressive behaviors to ensure their safety and that of those around them. Facility will put into place interventions for these residents if safety is not ensured. Monitoring: DON or designee ~~Facility~~ will review new aggressive behaviors at weekly at risk meeting to identify potential risk factors and implement interventions accordingly. Education: The NHA will provide education to clinical managers and applicable members of the IDT team on or before 5/20/22 regarding the at-risk meeting. The Social Service Director will trend and report any issues regarding aggressive residents brought forth through the at-risk meeting to the weekly/monthly QAPI committee X3 months or until resolution.	

7/15/22 - This POC accepted with agreed to changes between Matthew Overtman, Administrator and Tony Madden, State Health Surveyor. -dg

7/15/22

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F 600	Continued From page 2 use of prn Haldol this month." Review of the progress note dated 4/20/22 and timed 12:22 PM showed the resident was given Haldol due to agitation, yelling and accusing the laundry of stealing his/her clothes. Further review showed staff tried to redirect him/her, however s/he continued to yell at other residents about the laundry. Review of the progress note dated 4/26/22 and timed 4:04 PM showed resident #1 was upset about his/her roommate, resident #2. Resident #1 stated resident #2 turned off his/her television without permission. Further review showed the resident was yelling and showed aggression toward the staff by pushing a bedside table through the room-dividing curtain towards the staff. Review of the progress note dated 4/29/22 and timed 2:58 PM showed resident #1 was "very agitated" about his/her roommate and the television. Further review showed while maintenance was providing resident #1 with a different television remote, resident #1 called his/her roommate a "b*tch". The note further showed when resident #1 was returning to his/her room and saw the roommate in a common area, s/he yelled at the roommate calling him/her a "b*tch". Staff were able to prevent resident #1 from approaching the roommate at that time. The following concerns were identified: a. Review of the progress note for resident #1 dated 5/3/22 and timed 1:45 PM showed the writer "...heard screaming from room, CNA noted resident hitting [his/her] roommate in the face and [his/her] arm. Immediately intervened, resident swinging at the CNA also, resident assisted to stationary chair and roommate removed from room to safety...roommate and belongings	F 600		

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F 600	Continued From page 3 removed from room, resident is on 15 minute checks." b. Review of the SBAR Summary dated 5/3/22 and timed 1:45 PM showed resident #2 was in his/her room watching television when resident #1 came in the room, hit him/her, knocked his/her glasses off, and hit his/her right arm. Further review showed resident #2 had a bruise to the face and right wrist, and interventions included ice application to right cheek, and moving resident #2 to another room. Review of the Treatment Administration Record for May 2022 showed an order to monitor the bruising to resident #2's right cheek and right wrist until resolved. c. Interview with CNA #1 on 5/17/22 at 4:20 PM revealed on 5/3/22 resident #1 was agitated and threatening to kill his/her roommate. The CNA stated resident #1 came out to the common area. The CNA thought resident #1 had calmed down and saw the resident walk to to his/her room. The CNA stated resident #2 was in the room watching television. The CNA stated she heard screaming and yelling from the room and when she got to the room resident #1 stated s/he "hit the f*cking b*tch." The CNA stated she got between the residents and resident #1 hit her. She further stated the nurse came to the room and they immediately removed resident #2 from the room. d. Interview on 5/17/22 at 1:00 PM with resident #2 revealed s/he had a previous roommate (resident #1) who was upset with her over the television remote control. S/he said they were both able to change each other's channel and didn't know it. S/he stated resident #1 got	F 600		

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F 600	Continued From page 4 angry and hit him/her, and this upset resident #2. e. Interview on 5/17/22 at 4:25 PM with RN #1 revealed resident #1 had been agitated over the television remote and maintenance had changed the television and remote for resident #2. She stated resident #1 and resident #2 had been roommates for a short time. Resident #1 did not like having roommates, and was territorial. She further stated when the altercation occurred she and CNA #1 immediately removed resident #2 from the room. Resident #2 had a bruise on his/her face and on his/her wrist. She also stated they kept resident #2 at the nurse's station while they moved his/her belongings to another room. f. Review of the care plan for resident #1, with a revision date of 5/9/22, showed the resident displayed behaviors such as hitting staff, suicidal ideation, and resisting cares. Interventions included "...observe behavior episodes and attempt to determine underlying cause...document behavior and potential causes..." The care plan failed to show resident-specific non-pharmacological interventions for identifying and preventing an escalation of behaviors. 2. Interview on 5/18/22 at 12:24 PM with the DON revealed resident #1 had roommates in the past and there was not a problem. She stated resident #1 used to live in the main area, however s/he had violent behaviors towards staff and tried to elope. She stated they tried to transfer him/her to the psychiatric hospital, however they refused to take him/her. She stated since resident #1 had been in the secure unit his/her behaviors had diminished, s/he participated in activities, ate meals in the common area, and had a friend. She	F 600		

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F 600	Continued From page 5 stated when resident #2 returned to the facility from the hospital, they placed him/her in the secure unit and the only available room was with resident #1. She further stated after the 5/3/22 incident, she talked to resident #1 who told her s/he did not want any roommates and s/he would hurt any further roommates. The DON also stated after the incident they initiated 15 minute checks, but as soon as resident #2 was transferred to another room, resident #1 was happy and had not displayed any agitation since.	F 600		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758	F758 Correction: On or before 6/16/2022, ~~facility~~ will obtain a new order for the PRN medication from the physician or discontinue per physician preference. Identification: On or before 6/16/2022, ~~Facility~~ will audit all PRN orders of psychotropic medications and either obtain new orders for medication or set discontinue date per physician preference. All new admits will be audited for potential PRN medication that fit these criteria. NHA will educate Clinical Managers entering orders or before 6/16/2022 regarding PRN medications and psychotropics. Monitoring: ~~Facility~~ will address residents with PRN psychotropic medications at weekly at-risk meeting and contact physician to address medications within the 14-day time frame. Social service Director will monitor and trend any issues regarding PRN psychotropics brought forth through the at-risk meetings to the weekly/monthly QAPI meetings x3 months or until resolution.	

7/19/22

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F 758	Continued From page 6 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure when antipsychotic medications were ordered for prn use, the order was discontinued after no more than 14 days, or a new order was written after a direct examination by the attending physician for 1 of 1 residents (#1) reviewed for prn antipsychotic medications. The findings were: 1. Review of the 5/4/22 quarterly MDS assessment for resident #1 showed the resident was admitted on 9/3/20 with diagnoses which included metabolic encephalopathy, Alzheimer's disease, cognitive communication deficit, and unspecified dementia with behavioral	F 758		

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F 758	Continued From page 7 disturbance. The resident had severe cognitive impairment with a BIMS score of 4 out of 15. The resident also had physical and verbal behavioral symptoms on 1 to 3 days during the look back period. Review of the progress note dated 5/3/22 and timed 1:45 PM showed an administration note for Haldol (also known as haloperidol, an antipsychotic medication) given due to the resident acting belligerent and hitting his/her roommate. The following concerns were identified: a. Review of the May 2022 MAR showed an order for "Haloperidol tablet give 2 mg [milligrams] by mouth every 12 hours PRN [as needed] for behaviors/danger to self or others." Further review showed the medication was ordered on 12/1/21 and there was no stop date indicated on the order. b. Review of the "Medication Regimen Review" dated 12/21/21 showed a note from the pharmacist to the physician asking for a review of the PRN Haloperidol (Haldol) order, due to the order being over 14 days old. The physician wrote a note, which was dated 1/4/22, to "continue the prn Haldol, still necessary to prevent harm to others need to review in GDR [gradual dose reduction]." Further review of the medical record failed to show any evidence the physician examined the resident and documented the rationale and timeframe needed for a renewed PRN Haldol order. c. Review of the psychotropic medication management review dated 12/21/21 showed Haldol 2 mg every 12 hours PRN behaviors/danger to self and others was reviewed. The recommendations, which were signed by the physician on 12/21/21 showed "Continue Haldol prn risks greater than benefit for	F 758		

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F 758	Continued From page 8 when patient danger to self or others." Further review failed to show a time frame defined for the continued use of the medication. d. Medical record review failed to show a direct examination of the resident by the physician for the continued use of the PRN medication in December 2021. e. Interview on 5/17/22 with the social worker stated they review medications at the gradual dose reduction meetings and psychotropic medication management reviews, which were held quarterly. The social worker further stated the physician saw residents monthly.	F 758		

7/19/22