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 _____	10/06/2022

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 recertification survey was conducted by Healthcare Licensing a Surveys from 10/3/22 to 10/6/22. In addition, a review for compliance with the Omnibus COVID-19 Health care Staff Vaccination requirements was conducted. The following common abbreviations are used throughout the document: CDM: Certified Dietary Manager DON: Director of Nursing FA: Feeding Assistant NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		12/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2022

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 3 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents or resident representatives received a written transfer notice for 1 of 5 sample residents (#7) reviewed for hospitalization. The findings were: 1. Review of the medical record showed resident #7 was transferred to the hospital on 7/2/22 for an acute change of condition and readmitted to the facility on 7/5/22. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative. 2. Interview with the social service manager on 10/4/22 at 4:10 PM confirmed the written transfer/discharge notice was not provided to the resident or the resident's representative. 3. Review of the undated and unsigned "Discharge or Transfer" policy and procedure showed "1. Transfer/Discharge: Emergency...c. Complete transfer/discharge form and attach copies of..."	F 623	A discharge notice was submitted for resident #7 and presented to the resident and resident family representative. All residents that are transferred and or discharged have the potential to be affected. Measures put into place in order to ensure correction in these areas include: The Social Services Director and or designee will review census, transfer and discharges with the nursing department daily, Monday through Friday in order to ensure proper written transfer notice to the resident or the residents representative. Education will be completed with the Social Services Director and Social Services Assistant to ensure competency of written transfer notices. A bi-monthly audit will be completed by the Director of Nursing and or designee utilizing a transfer discharge report to confirm all written notices have been completed timely. All audit findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations to decrease audits frequency based on data presented. The Social Services Director and Director of Nursing are responsible for the compliance of this tag and reporting.	

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of the "Notice of Proposed Transfer/Discharge" form, and policy and procedure review, the facility failed to ensure residents or resident representatives received written information on the bed-hold policy for 1 of 5 samples residents (#7) reviewed for	F 625	A bed hold notice was submitted for resident #7 and presented to the resident and resident family representative. All residents that are transferred and or discharged have the potential to be affected.	12/1/22

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F 625	Continued From page 5 hospitalization. The findings were: 1. Review of the medical record showed resident #7 was transferred to the hospital on 7/2/22 for an acute change of condition and readmitted to the facility on 7/5/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 2. Interview with the social service manager on 10/4/22 at 4:10 PM confirmed the written transfer/discharge notice was not provided to the resident or the resident's representative. 3. Review of the undated and unsigned "Discharge or Transfer" policy and procedure showed "1. Transfer/Discharge: Emergency...c. Complete transfer/discharge form and attach copies of..." 4. Review of the "Notice of Proposed Transfer/Discharge" form showed a section was to be marked if the "Readmission and Bed Hold Policy" had been provided in writing to the resident, family member, surrogate or representative.	F 625	Measures put into place in order to ensure correction in these areas include: The Social Services Director and or designee will review census, transfer and discharges with the nursing department daily, Monday through Friday in order to ensure proper written transfer notice and bed hold notice to the resident or the resident□s representative. This will be monitored bi-monthly by the quality assurance committee until which time it is determined to no longer be necessary. Education will be completed with the Social Services Director and Social Services Assistant to ensure competency of written transfer notices. A bi-monthly audit will be completed by the Director of Nursing and or designee utilizing a transfer discharge report to confirm all written notices have been completed timely. All audit findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations. The Social Services Director and Director of Nursing are responsible for the compliance of this tag and reporting.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		12/1/22

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F 812	Continued From page 6 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the U.S. Public Health Service Food Code, the facility failed to ensure food was properly stored in 1 of 1 kitchen. In addition the facility failed to ensure proper hand hygiene during food preparation during 1 of 1 meal preparation observation. The census was 44. The findings were: 1. Observation on 10/3/22 at 2:15 PM and again on 10/5/22 at 8:45 AM showed a portable ice cream cart with 8 varieties of ice cream was located in the main kitchen. There was no evidence the temperature of the ice cream cart had been monitored. Interview with the CDM on 10/5/22 at 10:20 AM revealed the cart was used every Wednesday for an ice cream social with the residents. Further the CDM confirmed the temperature of the cart was not monitored.	F 812	A thermometer and temperature log were immediately put in place to ensure proper temperature of the ice cream cart. Education was done with all cooks in addition to all activities staff that aide in serving ice cream from the ice cream cooler. All refrigerator devices have the potential to be affected. A daily log will be kept regarding proper temperature maintenance of the ice cream cart. The Dietary Manager will be responsible to audit and ensure that the temperature log is maintained.	

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F 812	Continued From page 7 2. Observation on 10/5/22 beginning at 10:29 AM showed cook #1 was mixing a salad of tomatoes and lettuce with gloved hands and transferred the salad to a serving container. The cook doffed her gloves and without performing hand hygiene continued to cover the salad with plastic wrap and placed the salad into the walk-in refrigerator. Without performing hand hygiene the cook donned new gloves and placed raw meat patties into a pan on the stove. With her gloved hand, which had touched the raw meat, the cook adjusted the temperature knob on the stove and doffed her gloves. Without performing hand hygiene the cook gathered spices and seasoned the meat patties, donned oven mitts, and removed a pan of rice from the oven to prepare a puree. Without performing hand hygiene the cook donned new gloves and prepared the rice puree, doffed her gloves, and with no hand hygiene donned new gloves and transferred the pureed rice to a container and then placed the container on the steam table. At 10:46 AM the cook performed hand hygiene and with bare hands adjusted the temperature knob on the stove which had been previously touched with contaminated gloves. 3. Interview with dietary manager on 10/5/22 at 11:33 AM confirmed the dietary staff required more education on hand hygiene and the proper use of gloves. 4. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed	F 812	Immediate education was done with the cook in question regarding hand hygiene and proper changing of gloves. Education has been done with all cook staff regarding hand hygiene and proper changing of gloves. All residents have the potential to be affected by improper hand hygiene. A monthly audit will be completed by the Dietary Manager and or designee reviewing temperature logs. Weekly audits will be don regarding hand hygiene. All audit findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations. The Dietary Manager is responsible for the compliance of this tag and reporting.	

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F 812	Continued From page 8 FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (AC) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (Fé) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (HO) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for	F 888		12/1/22

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COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to

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F 888	Continued From page 10	F 888		

clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:

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F 888	Continued From page 11 (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility's staff vaccination records, and review of the policy and procedures, the facility failed to ensure 100% of staff were vaccinated against COVID-19, held	F 888	Immediate communication was made with the staff member in question and the second vaccination was obtained.	

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F 888	Continued From page 12 an exemption, or had a temporary delay. The facility's staff vaccination rate was 99%. The findings were: 1. Review of the facility's vaccination records showed FA #3 was hired on 8/11/22 and had received the first dose of the COVID-19 primary series on 6/13/22. There was no evidence the staff member had received the second dose. 2. Review of the "COVID-19 Vaccine" policy and procedure, last updated on 4/8/22, showed "newly hired employees will have received their first dose of Pfizer or Moderna or singular dose of Janssen prior to working in the community..." The policy failed to include a deadline for newly hired staff to have obtained the second dose of the primary vaccination series or indicate what the action would be if the deadline was not met. 3. Interview with the DON on 10/5/22 at 4:55 PM confirmed the staff member had not completed the COVID-19 primary dose vaccination series. In addition, the DON stated the facility did not have a system in place to ensure newly hired staff members had completed the vaccination series.	F 888	All new hires have the potential to be affected. Policy was updated to indicated that all staff members would either be fully vaccinated or have an approved exemption in order to work. The deadline for a second vaccination will be based on the CDC guidelines for given vaccination. If an employee is not vaccinated within the recommended guidelines they will be removed from the schedule until which time they are fully vaccinated or have an approved exemption in order to work. Policy review and education will done with Director of Nursing, all department heads and human resources to ensure policy is understood and followed. A monthly audit will be conducted by the Director of Nursing and or designee reviewing all new hire vaccinations along with partially vaccinated to ensure policy compliance. All audit findings will be reported in the Quality Assurance meeting quarterly, the team will monitor and make recommendations. The Director of Nursing are responsible for the compliance of this tag and reporting.	
F 948 SS=E	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding	F 948		12/1/22

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 _____	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 948	Continued From page 13 assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on review of facility records and staff interview, the facility failed to ensure paid feeding assistants had completed a State-approved training program. The facility had 10 residents which required assistance with eating and utilized 4 feeding assistants (FA #1, FA #2, FA #3, FA #4). The findings were: 1. Review of the facility's records showed 4 feeding assistants had been trained by the facility using a "Feeding Assistant Check-Off" form. FA #1 was trained on 1/25/22, FA #2 was trained on 7/28/22, FA #3 was trained on 8/20/22, and FA #4 was trained on 9/27/22. 2. Interview with the NHA on 10/4/22 at 4:47 PM confirmed the facility had not used a State-approved training program for training feeding assistants.	F 948	Feeding assistance were immediately removed from the schedule. All feeding assistance have the potential to be affected. The facility made the decision to immediately discontinue use of feeding assistants and will not pursue the State approved training program at this time.	