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 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR CASPER, WY 82601**

(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 4/13/23 to 4/14/23. The survey was prompted by complaint intake WY00003568. The following common abbreviations are used throughout this document: DON: Director of Nursing ADON: Assistant Director of Nursing CNA: Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		4/18/23

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

Electronically Signed | 05/02/2023

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 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility incident report review, State Survey Agency incident database review, and policy and procedure review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 2 of 11 sample residents (#1, #2). The findings were: 1. Interview with staff member #1 on 4/14/23 at 9:20 AM revealed resident #1 reported CNAs had grabbed him/her by the ankles and hurt him/her. The staff member revealed the resident had bruising on the ankles and after the allegation was made, no additional staff entered the room until the social services assistant began interviewing the resident. Further interview revealed the allegation occurred "about a month before [the resident] passed away" and the social services assistant reported the resident said s/he must have bumped him/herself. The following concerns were identified: a. Review of a progress note dated 1/11/23 and timed 6:07 PM showed "...Resident has bruise to right inner ankle. Investigated with [name], Social Services. Resident states that [s/he] is super itchy all over [his/her] body and [s/he] may have scratched at it. [S/he] also states	F 609	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #1 Allegation was reported, and	

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F 609	Continued From page 2 that [s/he] is on blood thinners (confirmed) and that [s/he] bruises easy and [his/her] itching with [his/her] other heel may have caused it. No reason to suspect abuse. Resident states [s/he], feels safe..." b. Interview with staff member #2 on 4/14/23 at 10:26 AM revealed the resident alleged someone had hurt him/her in the middle of the night and the resident had a new bruise on his/her ankle where the resident alleged s/he was grabbed. The staff member revealed the resident said CNAs were "rough" when they were changing him/her on the night shift. The staff member revealed she was informed of the allegation after the night shift had left. She reported the allegation to the administrator and social services, and the social services assistant interviewed the resident within 30 minutes of the report. c. Interview with the social services assistant on 4/14/23 at 1:23 PM revealed he was unable to find any notes related to the allegation a staff member hurt the resident. The social services assistant revealed he was prompted to interview the resident related to an allegation of abuse and confirmed the resident had bruising to his/her ankle. The social services assistant revealed when he interviewed the resident s/he said nobody had mistreated him/her. The social services assistant observed that the resident kept trying to reach for his/her legs. d. Review of an "Alleged Resident Physical or Verbal Abuse Incident Report" dated 1/11/23 showed the "Nature of suspected abuse" included a check mark for bruise. Further review showed the section for "Reportable Occurrence report filed with Health Department" was not completed. e. Review of the State Survey Agency incident database showed no indication this	F 609	thorough investigation completed. Plan of care updated. Resident #2 Allegation was reported, and thorough investigation completed. Plan of care updated. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All staff and interview-able residents we interviewed. Any identified allegations were reported and investigated. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed on 04/15/2023 with the NHA and DON by Vice President of Operations on process on identifying, preventing, and reporting abuse. Education completed on 04/17/2023 with IDT team and all staff by the VP of Operations and NHA on process on identifying, preventing, and reporting abuse. NHA/Designee will review and report all allegations of abuse timely. The NHA/SSD/Designee will investigate all allegations of abuse per regulation and facility policy. NHA/Designee will audit all investigations to ensure all components are completed	

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F 609	Continued From page 3 allegation of abuse was reported. 2. Interview with staff member #2 on 4/14/23 at 10:26 AM revealed she was aware of an incident of staff to resident abuse involving resident #2 which occurred recently. a. Review of the progress notes showed no evidence of an incident of staff to resident abuse involving resident #2. b. Review of the facility incident log showed no evidence of an incident of staff to resident abuse involving resident #2. c. Interview with the administrator, DON, and ADON on 4/14/23 at 12:15 PM confirmed staff member #3 reported she overheard resident #2 say another staff member had "smacked" him/her. Further interview revealed staff member #3 was unsure if she heard the resident correctly. d. Review of the State Survey Agency incident database showed no indication the allegation of abuse on 4/12/23 was reported. 3. Interview with the administrator and DON on 4/14/23 at 2:40 PM revealed the incidents should have been reported and were not and the team did not have a process for making the reports implemented at that time. Further interview revealed they thought the allegations had been reported. 4. Review of the policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" last revised 4/2021 showed "...1. If resident abuse, neglect, exploitation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or individual making the allegation	F 609	thoroughly and timely 3x per week for 4 weeks, then monthly for 2 months until substantial compliance is achieved. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The NHA/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 04/18/2023	

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F 609	Continued From page 4 immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility;...Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility incident investigation review, State Survey Agency incident database review, and policy and procedure review, the facility failed to ensure a thorough investigation was completed and to report the results of the investigation to the State	F 610	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED	4/18/23

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F 610	Continued From page 5 Agency for 2 of 11 sample residents (#1, #2) with allegations of abuse. The findings were: 1. Interview with staff member #1 on 4/14/23 at 9:20 AM revealed resident #1 reported CNAs had grabbed him/her by the ankles and hurt him/her. The staff member revealed the resident had bruising on the ankles and no additional staff entered the room until the social services assistant began interviewing the resident. Further interview revealed the allegation occurred "about a month before [the resident] passsed away" and the social services assistant reported the resident said s/he must have bumped him/herself. The following concerns were identified: a. Interview with staff member #2 on 4/14/23 at 10:26 AM revealed the resident alleged someone had hurt him/her in the middle of the night and the resident had a new bruise on his/her ankle where the resident alleged s/he was grabbed. The staff member revealed the resident said CNAs were "rough" when they were changing him/her on the night shift. The staff member revealed she was informed of the allegation after the night shift had left, reported the allegation to the administrator and social services, and the social services assistant interviewed the resident within 30 minutes of the report. b. Interview with the social services assistant on 4/14/23 at 1:23 PM revealed he was unable to find any notes related to the allegation a staff member hurt the resident. The social services assistant revealed he was prompted to interview the resident related to an allegation of abuse and confirmed the resident had bruising to his/her ankle. The social services assistant revealed when he interviewed the resident s/he said nobody had mistreated him/her and the resident	F 610	OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #1 Allegation was reported, and thorough investigation completed. Plan of care updated. Resident #2 Allegation was reported, and thorough investigation completed. Plan of care updated. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All staff and interview-able residents we interviewed. Any identified allegations	

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F 610	Continued From page 6 kept trying to reach for his/her legs. c. Review of an "Alleged Resident Physical or Verbal Abuse Incident Report" dated 1/11/23 showed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out 15. "Nature of suspected abuse" included a check mark for bruise. The section for "Reportable Occurrence report filed with Health Department" was not completed. Further review showed no evidence other resident interviews or stafff interviews were completed related to the allegation. d. Review of an "Occurence Documentation Checklist (revised 4/13/23)" provided by the facility on 4/19/23 showed it was completed for resident #1's allegation on 1/1/23 and signed on 4/17/23. Further review showed other resident interviews and family interviews were marked "n/a [not applicable]," and the ombudsman was not notified until 4/17/23. e. Review of the State Survey Agency incident database showed no indication a 1/11/23 allegation of abuse was reported for this resident. 2. Interview with staff member #2 on 4/14/23 at 10:26 AM revealed she was aware of an allegation of staff to resident abuse that involved resident #2. The following concerns were identified: a. Review of the progress notes showed no evidence of an allegation of staff to resident abuse for resident # 2. b. Review of the facility incident log showed no evidence of an allegation of staff to resident abuse for resident #2. c. Interview with the administrator, DON, and ADON on 4/14/23 at 12:15 PM confirmed staff member #3 reported she overheard resident #2 say another staff member had "smacked"	F 610	were reported and investigated. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed on 04/15/2023 with the NHA and DON by Vice President of Operations on process on identifying, preventing, and reporting abuse. Education completed on 04/17/2023 with IDT team and all staff by the VP of Operations and NHA on process on identifying, preventing, and reporting abuse. NHA/Designee will review and report all allegations of abuse timely. The NHA/SSD/Designee will investigate all allegations of abuse per regulation and facility policy. NHA/Designee will audit all investigations to ensure all components are completed thoroughly and timely 3x per week for 4 weeks, then monthly for 2 months until substantial compliance is achieved. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three	

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F 610	Continued From page 7 him/her. Further interview revealed staff member #3 was unsure if she heard the resident correctly and written statements were obtained for all staff members involved. d. Review of a written statement from staff member #3 dated 4/12/23 showed the staff member heard the resident yelling for help and the staff member went to the resident's room and found staff member #4 caring for the resident. Staff member #3 thought the resident said staff member #4 had hit him/her. e. Interview with staff member #3 on 4/14/23 at 1:46 PM revealed on 4/12/23 the staff member heard the resident "screaming," and upon entry to the room, observed staff member #4 providing care to the resident. Staff member #3 asked the resident why s/he was yelling and thought the resident said "she smacked me." Staff member #3 revealed staff member #4 began "nervously" talking over the resident and staff member #3 could not hear anything the resident was saying. Staff member #3 stated she took over care of the resident and asked the other staff member to leave the room. Staff member #3 revealed after she finished care of resident, she asked staff member #5 to talk to the resident to confirm she heard the resident say staff member #4 had hit him/her. Staff member #3 revealed she had not had previous issues or concerns with staff member #4. Further interview revealed she did not document the allegation in the resident's record; however, she was asked to provide a written statement. f. Interview with staff member #5 on 4/14/23 at 12:57 PM revealed on 4/12/23 staff member #3 reported she needed to speak to her. The staff members went outside and staff member #3 told her the resident had been yelling and the resident's yells were "different" than usual. Staff	F 610	months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The NHA/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 04/18/2023	

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F 610	Continued From page 8	F 610		

member #5 revealed staff member #3 said she entered the resident's room and asked the resident what was wrong. Staff member #5 revealed staff member #3 reported the resident said "she hit me". Staff member #5 revealed she went to the charge nurse and staff member #6, and both staff members interviewed the resident. Staff member #5 revealed when the resident was interviewed, s/he said staff member #4 did not hit him/her and s/he did not report s/he had been hit to staff member #3. Staff member #5 revealed staff member #6 contacted leadership after the interview and she was told by leadership the staff members should not have interviewed the resident. Further interview revealed leadership requested written statements from all staff members involved. Staff member #5 did not know of any previous issues between staff member #3 and staff member #4.

g. Review of the State Survey Agency incident database showed no indication an allegation of abuse of resident #2 on 4/12/23 was reported.

h. The facility did not provide any evidence, except written statements from staff involved, an investigation was completed.

i. Interview with the administrator and DON on 4/14/23 at 2:40 PM revealed an investigation should have been initiated immediately, and confirmed the facility failed to do so.

5. Review of the policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" last revised 4/2021 showed "...Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations...7. The individual conducting the investigation as a minimum: a. Reviews the documentation and evidence; b.

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F 610	Continued From page 9 reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person (s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly..."	F 610		