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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/27/23 to 3/31/23. The following common abbreviations are used throughout this document: BIMS- Brief interview for Mental Status CNA-- Certified Nurse Aide DON- Director of Nursing ED---- Executive Director LPN--- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set mg--- Milligrams QAPI- Quality Assurance Performance Improvement RN--- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		4/27/23

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

Electronically Signed | 04/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 1 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, beneficiary notice review, staff interview, and policy review, the facility failed to ensure the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) form was issued for 2 out of 4 (#7, #14) sample residents. The findings were: 1. Review of the "Notice of Medicare Provider Non-Coverage" (NOMNC) form completed by the facility showed resident #14 had a Medicare Part A stay that used fewer than maximum 100 days covered by Medicare Part A. Further review of the medical record showed Medicare A coverage ended on 3/3/23. The following concerns were identified: a. Review of the NOMNC form showed the facility failed to enter the correct Quality Improvement Organization (QIO) information for questions and/or appeals. b. Further review of the medical record failed to show evidence a copy of the signed NOMNC form was provided to the resident. 2. Review of the NOMNC form completed by the facility showed resident #7 had a Medicare Part A stay that used fewer than the maximum 100 days covered by Medicare Part A. Further review of the medical record showed Medicare A coverage ended on 8/5/22. The following concerns were identified: a. Review of the NOMNC form showed the facility failed to enter the correct Quality Improvement Organization (QIO) information for questions and/or appeals. b. Further review of the medical record failed to show evidence a copy of the signed NOMNC form was provided to the resident.	F 582	Preparation and execution of the 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 the state and federal 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 the State Operations Manual. F582/D 1) From survey date of compliance, Notices of Medicare provider non-coverage regulations are followed. 2) Initial audit completed by SSD over the last 60 days of NOMNC forms to assess for others who may have been affected by deficient practice. Resident #7 and # 27 are idientified. 3) Education provided by E.D./Designee to IDT related to the Notice of Medicare Provider Non-Coverage process, (NOMNC), form as well as education related to our current Quality Improvement organization, (QIO). Ongoing audits will be completed by E.D./Designee weekly times three months	

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	535036	A. BUILDING _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 582	Continued From page 3 3. Interview on 3/29/23 at 2:09 PM with the #Social Service Director (SSD) revealed the facility did not send any NOMNC forms per the requirements and did not know the correct QIO contact for appeals. 4. Review of the facility policy titled "Medicare Part A Denial of Coverage" last updated March 2019, showed "...The address and phone number of the state's QIO also included on the form... a copy is given to the resident/responsible party." 5. Review of the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" retrieved on 4/3/23 https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Instructions-for-Notice-of-Medicare-Non-Coverage-NOMNC.pdf showed: "A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC."	F 582	to assess the NOMNC process for completion. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	
F 600 SS=J	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		4/27/23

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 _____	03/31/2023

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F 600	Continued From page 4 §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, staff interview, facility-reported incident review, and policy review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 5 sample residents (#23) reviewed for allegations of abuse. This failure resulted in a determination of immediate jeopardy due to inadequate protections from sexual abuse for vulnerable residents. The findings were: 1. Review of the 1/20/23 quarterly MDS assessment for resident #23 showed the resident had a BIMS score of 4 out of 15, indicating the resident had significantly impaired cognition. The review showed the resident had diagnoses that included epilepsy, dementia, cognitive communication deficit, depression, irritability and anger. Further review showed the resident used a wheelchair for mobility, had disorganized thinking, and needed extensive assistance from staff for toileting, personal hygiene, and locomotion. 2. Review of the 12/19/22 quarterly MDS assessment showed resident #8 was admitted to the facility on 8/27/20 with diagnoses which included dementia, anxiety disorder, depression, and bipolar disease. The resident's brief interview for mental status score was 15 out of 15, which indicated the resident was cognitively intact. Review of the assessment at section G for transfer, walk in room, walk in corridor, locomotion on unit, and locomotion off unit showed the resident required only supervision, oversight, encouragement or cueing, and set up	F 600	F600/J 1) Resident #23 rights to be free from sexual abuse are in place including resident #8 is on a 1:1. 2) Initial audit completed by E.D./Designee to review risk management entries for the last 60 days to assess for others who may have been affected by deficient practice. No other aggressors have been identified. 3) Education provided to current staff by E.D./Designee related to abuse prevention and reporting of similar situations. Ongoing audits completed by IDT five days per week times three months during the morning clinical meeting to review risk management for similar situations to ensure appropriate measures are met related to prevention and reporting of abuse. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	

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 _____	03/31/2023

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F 600	Continued From page 5	F 600		

only. The area at section G showed the resident was not steady, but was able to stabilize without human assistance, and the resident utilized a walker.

3. Review of CNA behavior documentation for resident #8 from 2/28/23 to 3/29/23 showed the facility was monitoring the resident for behaviors that included the following: unsolicited sexual comments, gestures, touching staff or residents, masturbating and ringing call light (forced observation), and sexual gestures toward residents. The documentation noted the resident had one or more of these behaviors on 3/13/23 and 3/18/23, but did not specify what the behaviors were. The interventions noted on 3/13/23 and 3/18/23 were 1 to 1 supervision by staff.

4. Review of facility incident reports showed a 12/31/20 incident where it was reported resident #23's hands were "down" resident #8's pants. Further review showed a 3/18/23 incident where it was reported resident #8 was heard asking resident #23 "Do you want to suck it", while holding his/her genitals. The CNA #1 separated both residents, asking resident #8 to return to his/her room, explaining this was inappropriate behavior. The facility's interview with the CNA who witnessed the interaction revealed resident #8 did not have his/her genitals exposed, but was holding his/her genitals in his pants. The incident further noted that resident #8 was independently ambulatory with a front-wheeled walker, had a history of sexually inappropriate behavior, gestures, and vocalizations toward staff and others.

The follow concerns were identified:

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 _____	03/31/2023

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F 600	Continued From page 6	F 600		

a. Interview with CNA #1 on 3/30/23 at 9:43 AM revealed while she was working on 3/18/23, both residents were in the hallway when she heard resident #8 say to resident #23, "Do you want to suck it". When the CNA approached the residents she saw that resident #8 had his/her pants halfway between his/her waist and hips, with his/her hands in the pants, grabbing his/her own genitals and standing with his/her genitals close to the face of resident #23, who was sitting in a wheelchair. The CNA stated resident #23 "was leaning forward like [s/he] was going to suck it if I had not intervened". The CNA then separated both residents. The CNA stated management provided verbal education after the incident. The education consisted of keeping "those two residents separated".

b. Further review of the 12/19/22 quarterly MDS assessment showed resident #8 ambulated independently with the use of a walker. Review of the assessment at section G for transfer, walk in room, walk in corridor, locomotion on unit, and locomotion off unit showed the resident required only supervision, oversight, encouragement or cueing, and set up only. The area at section G also showed the resident was not steady, but was able to stabilize without human assistance, and the resident utilized a walker.

c. Review of the 3/15/23 "Psychotropic Drug and Behavior Monthly" form for resident #8 showed the resident came out of his/her room for meals and activities, had been doing well with his/her depressive-like behaviors, and had been doing well overall. The resident received mental health therapy about every other week and appeared to be reaching his/her highest functional level. Further review showed the resident had no new behaviors since the last review and the resident's overall behaviors

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 600	Continued From page 7	F 600		

continued to decrease with the current medication regimen. The interdisciplinary team recommended that the resident continue to be monitored regarding behaviors. However, the facility failed to address or investigate the sexually inappropriate behavior documented by CNAs on 3/13/23.

d. Interview with CNA #4 on 3/30/23 at 1:30 PM revealed her concern that other residents were not safe around resident #8, noting the resident continued to make inappropriate comments.

e. Interview with CNA #5 on 3/30/23 at 3:10 PM, revealed the CNA had witnessed two separate occasions last year (2022) when resident #23 had his/her hand in resident #8's pajama pants, and the police were called after the second incident. After the second incident CNA #5 said she asked resident #23 if s/he knew what was going on, and resident #23 replied to CNA #5 s/he did not know and that resident #8 had told him/her it was a game. CNA #5 also stated s/he felt the facility failed to prevent the behavior because it kept happening. S/he also stated that resident #23 did not provoke these behaviors and did not have the capacity to do so, that s/he was a "follower and didn't think of the ideas first." She also stated her opinion resident #8 had targeted resident #23 because s/he could get away with it.

f. An additional interview with CNA #1 on 3/30/23, at 5:30 PM confirmed her original written statement and further added that resident #8 did not reveal his/her genitals at that time, his/her pants were at his/her hips and the CNA was glad she caught them and stopped it from happening because she "did not want that for anyone."

g. Interview with CNA #3 on 3/30/23 at 1:45 PM revealed resident #8 often made sexual

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 600	Continued From page 8	F 600		

comments about others. She also stated the resident could be redirected; however s/he "just does it again," and the CNA felt that the resident would continue to manipulate vulnerable residents. The CNA also confirmed that resident #23 did not solicit sexual comments or behaviors from others.

h. Review of resident #8's room change notice dated and signed on 3/20/23 showed the room change was "due to safety issues" and "repeated occurrences" with fellow residents. Review of the progress notes for resident #8 showed on 3/18/23 at 10:24 AM, "It was reported to the nurse this resident was in the hall, approached another resident, pulled down [his/her] own pants, and asked the other resident to suck it. The CNA then confronted and redirected both residents, and notifications were made." Further review showed resident #8 was moved from room #38 to room #7 due to an incident with another resident. However, the facility failed to change the resident's room until 2 days after the incident.

i. Review of resident #8's care plan, last revised on 8/1/22, failed to show any new revisions or interventions since 6/8/22.

j. Review of the facility staff education dated 3/30/23 titled "Staff Education on Monitoring Resident while in common areas throughout the building", showed "Due to recent incidents with [resident #8], we must monitor [his/her] whereabouts throughout the facility at all times, especially during times when other vulnerable residents are around. Please read and sign." Further review showed 19 signatures on the document.

k. Interview with the ED on 3/30/23 at 9:15 AM revealed the facility was unable to do a root cause analysis because resident #8 chronically

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

(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 600	Continued From page 9	F 600		

denied any and all allegations of sexual misconduct, and the resident had cycles of misbehaving. The ED stated they moved the resident closer to the manager's offices to help monitor but did not have a staff member continuously observing the resident for prevention and safety.

5. Review of the facility policy titled "Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation." last updated September 2017, definitions showed:
-Sexual Abuse: Non-consensual sexual contact of any type with a resident. It includes but is not limited to: Unwanted intimate touching of any kind, especially of breast or perineal areas; Forced observation of masturbation and/or pornography; and... Generally, sexual contact is non-consensual if the resident either: Appears to want the contact to occur, but lacks the cognitive ability to consent.
-Mistreatment: Inappropriate treatment or exploitation of a resident.
-Exploitation: Taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

6. Review of the facility policy titled "Prevention of all Types of Abuse, Neglect, Mistreatment, Involuntary Seclusion, Exploitation, and Misappropriation of Resident Property" last updated October 2022, showed the following: 7 .... Correct and intervene in reported identified situations in which abuse, neglect, exploitation, or misappropriation is more likely to occur by analyzing the following...b ....confirm that the staff assigned has knowledge of the individual residents' care needs and behaviors;..e. The

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 600	Continued From page 10	F 600		

identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: i. Verbally aggressive behavior; ii. Physically aggressive behavior; iii. Sexually aggressive behaviors such as saying sexual things, inappropriate touching, grabbing; ...vii. Residents with communication disorder or language barrier; ...9. Residents identified by staff as being self-injurious or exhibiting abusive behavior ...are reviewed...Referrals are made and treatment plans modified as appropriate."

7. Review of the facility policy titled "Abuse Protection" last updated October 2022, showed "...1. The Center responds immediately to suspicion and/or allegations of abuse ....in order to protect the victim and the integrity of the investigation ...5. The Center suspends and/or removes the alleged perpetrator from the patient care area immediately ...6. The Center changes the resident's room and/or assigned staff as necessary to protect the resident ...7. The Center increases supervision of the alleged victim and other residents as determined by the Executive Director/designee."

8. Review of the facility policy titled "Abuse Identification" last updated October 2022 showed ...4 ...The Quality Assurance and Performance Improvement (QAPI) program, investigates occurrences, patterns, and trends that may indicate the presence of abuse...to determine the direction of investigation/interventions, through analysis of systems, audits, and reports.

On 3/30/23 at 2:45 PM the ED was informed of an immediate jeopardy situation in the regulatory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

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F 600	Continued From page 11	F 600		

area of freedom from abuse, neglect, and exploitation.

The facility submitted an action plan which included the following immediate changes:

"...Corrective Action:

Identified Resident was put on one to one observation on 3/30/23 at 2:50 PM related to an incident occurring on 3/18/23.

Identification of others:

Initial audit completed of 25% random residents to assess for others who may have been affected. Re-interview of the only eye witness and other staff completed by Executive Director and Divisional Director of Clinical Operations.

Systemic Change:

Re-education provided to all staff related to one on one status of identified Resident. Executive Director/Designee will audit one on one assignment sheet daily times three months for one on one compliance.

Monitoring:

Ad hoc QAPI meeting held with Medical Director at approximately 6:15 PM on 3/30/23 to discuss immediate jeopardy specifics as described by surveyors. Results of initial as well as ongoing audits will be monitored via the QAPI process monthly times three months for further recommendations..."

The action plan was accepted on 3/31/23 at 11:42

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 600	Continued From page 12 AM. The implementation of the plan was verified and immediacy was removed on 3/31/23 at 11:42 AM; however, deficient practice remained at a scope of "G", as a reasonable person would feel intimidated, humiliated or demeaned by the behavior.	F 600		
F 610 SS=E	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, incident review, and facility policy review, the facility failed to ensure adequate protective measures were in place to prevent abuse for 1 of 5 sample residents (#8) reviewed. The findings were:	F 610	F610/E 1) Resident #23 rights to be free from sexual abuse are in place including resident #8 is on a 1:1. 2) Initial audit completed by E.D./Designee to review risk management entries for the last 60 days to assess for	4/27/23

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 610	Continued From page 13 1. Review of the 12/19/22 quarterly MDS assessment for resident #8 showed the resident has a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Review of the assessment at section G for transfer, walk in room, walk in corridor, locomotion on unit, and locomotion off unit showed the resident required only supervision, oversight, encouragement or cueing, and set up only. The area at section G showed the resident was not steady, but was able to stabilize without human assistance, and the resident utilized a walker. Review of facility-reported incidents showed a 3/18/23 incident where it was reported resident #8 was heard asking resident #23 "Do you want to suck it", while holding his/her genitals. CNA #1 separated both residents, asking resident #8 to return to his/her room, explaining this was inappropriate behavior. The facility's interview with the CNA who witnessed the interaction revealed resident #8 did not have his/her genitals exposed, but was holding his/her genitals in his/her pants. The incident further noted that resident #8 was independently ambulatory with a front-wheeled walker, had a history of sexually inappropriate behavior, gestures, and vocalizations toward staff and others. The follow concerns were identified: a. Interview with CNA #1 on 3/30/23 at 9:43 AM revealed while she was working on 3/18/23, both residents were in the hallway when she heard resident #8 say to resident #23, "Do you want to suck it". When the CNA approached the residents she saw that resident #8 had his/her pants halfway between his/her waist and hips, with his/her hands in the pants, grabbing his/her	F 610	others who may have been affected by deficient practice. No other aggressors have been identified. 3) Education provided to current staff by E.D./Designee related to abuse prevention and reporting . Ongoing audits completed by IDT five days per week times three months during the morning clinical meeting to review risk management for similar situations to ensure appropriate measures are met related to prevention and reporting of abuse. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	

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	535036	A. BUILDING _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 14	F 610		

own genitals and standing with his/her genitals close to the face of resident #23, who was sitting in a wheelchair. The CNA stated resident #23 "was leaning forward like [s/he] was going to suck it if I had not intervened". The CNA separated the residents. The CNA stated management provided verbal education after the incident. The education consisted of keeping "those two residents separated."

b. Interview with CNA #4 on 3/30/23 at 1:30 PM revealed her concern that other residents were not safe around resident #8, noting the resident continued to make inappropriate comments.

c. Interview with CNA #5 on 3/30/23 at 3:10 PM, revealed the CNA had witnessed two separate occasions last year (2022) when resident #23 had his/her hand in the fly of resident #8's pajama pants, and the police were called after the second incident. After the second incident CNA #5 said she asked resident #23 if s/he knew what was going on, and resident #23 replied to CNA #5 s/he did not know and that resident #8 had told him/her it was a game. CNA #5 also stated s/he did not feel the facility kept resident #23 safe because it kept happening. S/he also stated that resident #23 did not provoke these behaviors and did not have the capacity to do so, that s/he was a "follower and didn't think of the ideas first." She also stated her opinion resident #8 had targeted resident #23 because s/he could get away with it.

d. An additional interview with CNA #1 on 3/30/23, at 5:30 PM confirmed her original written statement and further added that resident #8 did not reveal his/her genitals at that time, his/her pants were at his/her hips and the CNA was glad she caught them and stopped it from happening because she "did not want that for

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	535036	A. BUILDING _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 610	Continued From page 15	F 610		

anyone."

e. Interview with CNA #3 on 3/30/23 at 1:45 PM revealed resident #8 often made sexual comments about others. She also stated the resident could be redirected; however s/he "just does it again," and the CNA felt that the resident would continue to manipulate vulnerable residents. The CNA also confirmed that resident #23 did not solicit sexual comments or behaviors from others.

f. Review of resident #8's room change notice dated and signed on 3/20/23 showed the room change was "due to safety issues" and "repeated occurrences" with fellow residents. Review of the progress notes for resident #8 showed on 3/18/23 at 10:24 AM, "It was reported to the nurse this resident was in the hall, approached another resident, pulled down [his/her] own pants, and asked the other resident to suck it. The CNA then confronted and redirected both residents, and notifications were made." Further review showed resident #8 was moved from room #38 to room #7 due to an incident with another resident. However, the facility failed to change the resident's room until 2 days after the incident.

g. Review of the facility staff education dated 3/30/23 titled "staff education on monitoring resident while in common areas throughout the building", showed "Due to recent incidents with [resident #8], we must monitor [resident #23's] whereabouts throughout the facility at all times, especially during times when other vulnerable residents are around."

h. Interview with the ED on 3/30/23 at 9:15 AM revealed the facility was unable to do a root cause analysis because resident #8 chronically denied any and all allegations of sexual misconduct, and the resident had cycles of misbehaving. The ED stated they moved the

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

(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 610	Continued From page 16	F 610		

resident closer to the manager's offices to help monitor but did not have a staff member continuously observing the resident for prevention and safety.

2. Review of the facility policy titled "Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation." last updated September 2017, definitions showed:
-Sexual Abuse: Non-consensual sexual contact of any type with a resident. It includes but is not limited to: Unwanted intimate touching of any kind, especially of breast or perineal areas; Forced observation of masturbation and/or pornography; and... Generally, sexual contact is non-consensual if the resident either: Appears to want the contact to occur, but lacks the cognitive ability to consent.
-Mistreatment: Inappropriate treatment or exploitation of a resident.
-Exploitation: Taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

3. Review of the facility policy titled "Abuse Protection" last updated October 2022, showed "...1. The Center responds immediately to suspicion and/or allegations of abuse ....in order to protect the victim and the integrity of the investigation ...5. The Center suspends and/or removes the alleged perpetrator from the patient care area immediately ...6. The Center changes the resident's room and/or assigned staff as necessary to protect the resident ...7. The Center increases supervision of the alleged victim and other residents as determined by the Executive Director/designee."

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 17 4. Review of the facility policy titled "Abuse Identification" last updated October 2022 showed ...4 ...program, investigates occurrences, patterns, and trends that may indicate the presence of abuse...to determine the direction of investigation/interventions, through analysis of systems, audits, and reports.	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit.	F 636		4/27/23

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 636	Continued From page 18 (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility policy review, and review of the CMS Resident Assessment Instrument (RAI) manual version 3.0, the facility failed to ensure comprehensive assessments were completed within 14 days after admission for 2 of 2 sample residents (#19, #28) reviewed for timely	F 636	F636/D 1) Residents #19 and #28, since survey of compliance date will have RAI compliance assessment completed timely per ARD date. 2) Initial audit completed by E.D./Designee of last ten ARD dates to	

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 636	Continued From page 19 comprehensive MDS completion. The findings were: 1. Review of the medical record for resident #19 showed the resident was admitted to the facility on 2/10/23. Review of the admission MDS assessment showed an ARD of 2/23/23 and section Z0500 showed the RN assessment coordinator had signed the assessment as completed on 3/1/23 (5 days late). 2. Review of the medical record for resident #28 showed the resident was admitted to the facility on 12/23/22. Review of the admission MDS assessment showed an ARD of 1/3/23 and section Z0500 showed the RN assessment coordinator signed the assessment as completed on 1/18/23 (12 days late). Further review of the MDS summary report showed the MDS assessment, the care plan decisions, and associated care area assessments (CAAs) were completed on 1/5/23. The following concerns were identified: 3. Interview with the MDS Coordinator on 3/30/23 at 9:50 AM confirmed the completion dates were late. 4. Review of the facility policy titled "Resident Assessment Instrument Process- MDS Scheduling) last updated March 2019 showed, "The Center completes Minimum Data Set (MDS) assessments to satisfy the Omnibus Budget Reconciliation Act (OBRA) requirements for admission, quarterly...". 5. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual showed "...The MDS completion date	F 636	assess for residents who may have been affected by deficient practice. 3) MDS Coordinator has been provided education by the E.D related to the importance of timely assessments related to ARD dates. Ongoing audits completed twice weekly by E.D./Designee for newly assigned ARD dates for the timely completion of assessments per ARD dates. 4) Results of initial as well as ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations. 5) DOC :04/27/2023	

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 636	Continued From page 20 (item Z0500B) must be no later than day 14..."	F 636		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its	F 801		4/27/23

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

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F 801	Continued From page 21	F 801		

successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 801	Continued From page 22 managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and class enrollment documentation review, the facility failed to ensure a full-time staff member with the required competencies managed the dietary department. The findings were: Interview on 3/27/23 at 12:51 PM with the dietary manager revealed she was not certified as a dietary manager. She further confirmed the facility had a contracted registered dietitian who was not present for the day to day operation of the dietary department, but could take calls from the facility as needed. Review of the class enrollment receipt showed the dietary manager had enrolled in an acceptable on-line class on 3/29/23 at 1:53 PM to become a certified dietary manager.	F 801	F801/D 1) Current dietary staff member completed the IFSEA, Certified Food Manager Course on 05/11/2023. 2) E.D. will be mentoring staff member assisting with education towards certification. 3) E.D will meet with Certified Food Manager candidate weekly for educational progress and testing updates, and report to state agency monthy on progress. 4) Results of ongoing educational processes and testing will be reviewed via the QAPI process monthly times three months for further recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		4/27/23

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 880	Continued From page 23 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

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F 880	Continued From page 24 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure the proper use of PPE during blood glucose testing and failed to ensure adequate disinfection of glucometers during 1 random observation. Observation on 3/29/23 at 10:47 AM showed LPN #2 gathered the glucometer, lancet, alcohol pad, and test strip while at the nurse's station medication cart at the front of the facility. The LPN performed hand hygiene, prepared the supplies, and inserted the test strip into the glucometer. The LPN then walked to the resident's room and placed the glucometer on top of the blanket which covered the resident's abdomen. The LPN picked up the glucometer for the test, then placed the glucometer back on the blanket. The glucometer was not disinfected at this time. The LPN failed to don gloves when performing the glucose test. No barrier was used between the glucometer and supplies, and the resident's blanket. The LPN left the resident's room after completing	F 880	F880/D Education provided to LPN #2 by DNS and DDCO on 3/30/23, regarding policies and procedures on handwashing, appropriate PPE, donning and doffing PPE, and glucometer practices. 1. Initial audit on handwashing, PPE, donning and doffing, and glucometer practices was completed by DNS and ED immediately after deficiency was brought to Administration by survey team, with identified concerns corrected as necessary. 2. Education provided to staff regarding handwashing, PPE, donning and doffing, and glucometer usage and practices. 3. ED/Designee will audit weekly for twelve weeks and then monthly for three months including hand hygiene compliance, the use of PPE, donning and doffing PPE, and disinfecting resident care equipment. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and	

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 _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 25 the test and placed the contaminated glucometer on the medication cart. The LPN also took the used test strip out of the glucometer and threw it in the biohazard container without donning gloves. Interview with the LPN at that time revealed s/he should have utilized appropriate personal protective equipment at that time to include gloves. Interview with the DON on 3/29/23 at 11:40 AM revealed the staff were expected to wear gloves during glucose testing related to contamination risk for blood borne pathogens. Also, a barrier should be placed between the glucometer and the environment, and bleach wipes should be utilized to disinfect glucometers between each resident use.	F 880	discussion of continuation or discontinuation of audit based on results. 4. Date of Compliance: 04/27/23	