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 08/03/2023

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 8/2/23 through 8/3/23. The survey was prompted by complaint intake WY000003645.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced	F 563		8/23/23

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

Electronically Signed | 08/20/2023

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F 563	Continued From page 1 by: Based on resident representative interview, staff interview, medical record review, and policy and procedure review the facility failed to ensure residents were allowed visitation for 1 of 6 sample residents (#2). The findings were: 1. Review of the medical record for resident #2 showed the resident re-admitted to the facility with orders for comfort focused care on 7/25/23 and an allegation of abuse by family members was reported on 7/29/23. Further review showed the resident was evaluated by hospice on 7/30/23 and discharged from the facility on 7/31/23. Review of a "Durable Power of Attorney and Authority to Access Health Information" dated 11/2/15 identified the resident's grandson as the durable power of attorney. The following concerns were identified: a. Interview with the social services director on 8/3/23 at 10:19 AM revealed the grandson visited the resident on 7/29/23 and he was told family was not able to visit the resident due to an ongoing investigation and the social services director notified local law enforcement. The social services director stated the grandson left the facility for approximately 1.5 hours when he returned to meet with law enforcement; however, he stayed in the lobby during the interview with law enforcement. The social services director revealed law enforcement told the facility and the grandson he could visit the resident as he was not identified in the allegation. However, he stated the administrator was not notified the grandson was allowed to visit. b. Interview with Registered Nurse (RN) #1 on 8/3/23 at 12:11 PM confirmed the grandson was allowed to visit the resident on 7/29/23; however, the administrator told the grandson he	F 563	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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. 1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 2 moved to Hospice facility on 7/31/23. 2. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other resident concerns identified. Any	

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F 563	Continued From page 2 could not be at the facility on 7/30/23. c. Interview with the grandson on 8/3/23 at 12:43 PM confirmed the resident was on end of life care and he was not allowed to visit the resident on 7/29/22 upon start of an investigation and again on 7/30/23. He revealed he was told he was not identified in the allegation of abuse. d. Interview with the administrator on 8/3/23 at 1:35 PM confirmed an abuse investigation was initiated following an allegation of abuse by the resident's family members and he notified the grandson he could not visit the resident. Further interview revealed the administrator "did not know the grandson was not involved at that time" and he wanted to keep the resident safe. 2. Review of the "Bill of Rights for Residents of Nursing home" made by Compliance Poster Company, hand delivered by the administrator on 8/2/23 at 1:02 PM showed "...Receive visitors during visiting hours ..." 3. Review of the policy titled "Resident Right to Access and Visitation" provided by the Director of Nursing (DON) on 8/3/23 at 2:20 PM showed "...2. The facility will provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at the time. Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, placed by the facility according to CDC guidelines, and/or local health department recommendations...7. The facility will inform each resident of the right, subject his or her consent, to receive the visitors who he or she designates as well as deny visitation, including but not limited to: ...c. Another family member ..."	F 563	resident denied visitation due to active abuse accusations is at risk due to deficient practice. 3. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: a. Facility created visitation protocol to allow supervised visitation with a “safety plan” if there is active abuse allegation investigation and the resident is unable to communicate desire for visitation, i.e. end of life, sever cognitive impairment. b. All staff educated on resident right for visitation and visitation protocol during active abuse investigation process on 08/01/2023 by the NHA. c. SSD educated by Director of Clinical compliance on 08/18/2023 through investigation requirements including alleged assailant interview statements as allowed by alleged assailant. d. Point person protocol established for coordinating communication of investigation status to resident/POA and IDT team. 4. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: a. DON/Designee will monitor visitation access for all residents involved with abuse allegations weekly for every occurrence x 90 days. b. DON/designee will ensure complete and accurate skin check completed the	

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F 563	Continued From page 3	F 563	day of alleged abuse is reported. Monitoring will be completed weekly for every occurrence x 90 days by the DON/Designee. c. DON/Designee will ensure a designated point person communication and safety plan (as indicated) are implemented and followed for every occurrence of such nature weekly x 90 days. d. Any findings will be reported to the monthly Quality Assurance Performance Improvement (QAPI) Committee 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 DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. 5. Date of Compliance 08/23/2023	
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.	F 610		8/23/23

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F 610	Continued From page 4 §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 review of investigation documentation, resident representative and staff interview, medical record review, and policy and procedure review, the facility failed to ensure a thorough investigation was performed for 1 of 2 sample residents (#2) reviewed for allegations of abuse. The findings were: 1. Review of investigation documentation provided by the social services director on 8/3/23 showed an allegation of abuse was received from the facility's compliance hotline on 7/29/23 at 11:35 AM. Review of a "Skin-Weekly Head to Toe Skin Checks" dated 7/25/23 and timed 11:21 PM showed "resident still has many bruises on arms and legs where [s/he] bumps them on things and falls." The following concerns were identified: a. Interview with the resident's grandson on 8/3/23 at 12:43 PM revealed after attempting to advocate for the resident and a stern conversation with a certified nurse aide (CNA), an allegation of abuse was made toward two members of his family. He stated he was not part of the investigation. b. Interview with the facility administrator on 8/3/23 at 1:35 PM confirmed the facility initiated an abuse investigation following an allegation against the resident's family. c. Interview with CNA #2 on 8/3/23 at 9:34 AM	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 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 THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. 1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 2 moved to Hospice facility on	

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F 610	Continued From page 5 revealed on 7/25/23 she witnessed 2 female family members of the resident grab the resident's shoulders and force the resident to lay back down in the bed. The CNA revealed one of the family members grabbed the resident's feet and dropped them back on the bed. Further interview revealed she reported the allegation of abuse. d. Review of the medical record showed no evidence a skin assessment was performed and no new injuries were identified following the allegation of abuse. e. Interview with the social services director on 8/3/23 at 10:19 AM revealed during the investigation he interviewed 1 Registered Nurse (RN), 1 dietary aide, and 2 CNAs. Further interview revealed the resident was not interviewed due to confusion and no family members were interviewed related to the allegation; however, he substantiated the allegation based on the interview of 1 staff member. He confirmed a thorough investigation was not completed. 2. Review of policy titled "Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating" last revised April 2021 showed "...Investigating Allegations 1. All allegations are thoroughly investigated... 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. 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; f. interview the resident (as medically appropriate) or the resident's representative; h. interviews staff members (on all shifts) who have	F 610	7/31/23. 2. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No other resident concerns identified. Any resident denied visitation due to active abuse accusations is at risk due to deficient practice. 3. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: a. Facility created visitation protocol to allow supervised visitation with a “safety plan” if there is active abuse allegation investigation and the resident is unable to communicate desire for visitation, i.e. end of life, sever cognitive impairment. b. All staff educated on resident right for visitation and visitation protocol during active abuse investigation process on 08/01/2023 by the NHA. c. SSD educated by Director of Clinical compliance on 08/18/2023 through investigation requirements including alleged assailant interview statements as allowed by alleged assailant. d. Nursing management was educated by Director of Clinical compliance on 08/18/2023 that skin check must be completed at the time of abuse allegation to assess for injury. e. Point person protocol established for coordinating communication of	

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F 610	Continued From page 6 had contact with the resident during the period of the alleged incident; j. interviews the resident's roommate, family members and visitors; k. reviews all events leading up to the alleged incident, and documents the investigation completely and thoroughly ..."	F 610	investigation status to resident/POA and IDT team. 4. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: DON/Designee will monitor visitation access for all residents involved with abuse allegations weekly for every occurrence x 90 days. DON/designee will ensure complete and accurate skin check completed the day of alleged abuse is reported. Monitoring will be completed weekly for every occurrence x 90 days by the DON/Designee. DON/Designee will ensure a designated point person communication and safety plan (as indicated) are implemented and followed for every occurrence of such nature weekly x 90 days. Any findings will be reported to the monthly Quality Assurance Performance Improvement (QAPI) Committee 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 DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. 5. Date of Compliance 08/23/2023	