STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION AT CASTLE ROCK	**1445 UINTA DRIVE GREEN RIVER, WY 82935**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/16/24 to 1/19/24. Also reviewed in the course of the survey was complaint intake WY00003545. The following common abbreviations are used throughout this document: MDS: Minimum Data Set MA-C: Certified Medication Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure resident choice of activities was provided for 1 of 1 sample resident (#26) with activity concerns. The findings were:	F 679	Resident #26 was immediately assessed by Activities Director and Social Services Director, initial assessment was reviewed and resident was offered religious 1:1, religious group programs, social services 1:1, counseling and an opportunity to make suggestions for more men specific	2/16/24

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

Electronically Signed | 02/08/2024

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F 679	Continued From page 1 1. Review the admission MDS assessment dated 9/1/23 showed resident #26 had cognition which was moderately impaired and the preferences for customary routine and activities showed the news was very important and fresh air was somewhat important. Further review showed the resident had diagnoses which included cerebral infarction, difficulty in walking, muscle weakness, and hemiplegia. The following concerns were identified: a. Observation on 1/16/24 at 3:23 PM showed the resident was sitting on the edge of his/her bed, with the TV on. Interview at that time revealed the facility didn't have activities for younger residents, and the resident didn't like bingo. b. Observation on 1/17/24 at 11 AM showed the resident was in his/her room, lying on the bed, watching television. c. Observation on 1/18/24 01:29 PM showed the resident was in his/her room, lying on the bed, watching television. Interview with the resident at that time revealed the facility did not provide 1:1 activities including offering books, audio books, or music. d. Review of a progress note dated 12/28/23 and timed 11:28 AM Social Services Notes showed "...Social Services Sections of the Quarterly MDS Review Complete. [Resident name] continues in [his/her] routine spending much of [his/her] time throughout the care community here. [S/he] is alert, oriented, and able to make [his/her] wishes known with little confusion noted. S/he is pleasant and cooperative in his/her cares. [Resident name] is here as a long-term placement, though s/he would like to transfer to [another location] once a bed opens. A referral was sent and [s/he] is on the waiting list... Social Services will continue to	F 679	activities on the calendar. All residents have the potential to be affected. All residents care plans will be reviewed and updated, 1:1's will be addressed to ensure that individualized activities and interventions for residents occurs according to plan of care. Activity calendar was updated to include coffee and current events, men's specific activities, some physical games, table top games have been ordered and weather permitting outings in the future along with age appropriate activities. Education has been done with Activities Director regarding initial assessments and care plans to ensure that the residents are supported by activities to attain and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The Social Services Director and or designee will conduct weekly audits of a minimum of 4 residents to include care plans, comprehensive assessments and activities offerings to ensure proper practice. Audits findings will be presented to the QUAPI team quarterly and assessed. The team will review and make recommendations.	

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F 679	Continued From page 2 visit with the resident and assist as needed..." e. Review of the care plan last revised on 9/15/23 showed "[residents name] has refused all group program invitations to date and has shown disinterest in visits. [S/He] has been observed to be watching television during most of available leisure time. Preferred leisure activity provides few opportunities for socialization or mental stimulation. [S/He] may need gentle and gradual encouragement to broaden recreation and leisure pursuits. The goals were [resident name] will talk to staff/volunteers during one-on-one visits, and [resident name] will identify 2 new potential leisure interests during leisure education visits by re-evaluation date through review date 2/25/24." f. Review of the activities assessment provided by the facility on 1/18/24 at 11:15 AM showed the resident's favorite book genre was mystery, s/he liked rock and roll music, s/he liked to watch television, and s/he liked to get outside for fresh air. Review of the monthly activities calendar which documented participation in activities for January 2024 showed the resident routinely accepted a snack for activity participation. Further review showed no 1 on 1 activity was offered, and the resident refused 1 group activity. There were no other documented activities offered, accepted, or refused. g. Interview with the activities coordinator on 1/18/24 at 11:15 AM revealed the facility offered the resident snacks daily and documented it as activity participation; however, she confirmed resident's receiving snacks was not an activity. Further interview confirmed there was no evidence of 1 to 1 activity offerings, participation, or refusals. h. Interview with the clinical vice president on 1/18/24 at 3:09 PM revealed if a resident does not come down for an activity, then a 1:1 should	F 679	The Social Services Director is responsible for the tag and reporting.	

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F 679	Continued From page 3 be provided. Further interview confirmed daily snacks were not an activity or a 1 to 1 visit. 2. Review of the "Recreation Therapy and Engagement Programs" policy hand delivered on 1/18/24 at 4:28 PM showed "...The recreation therapy and engagement services for MHS provides individualized activities and interventions for all residents in our communities... The goal is for each resident to be autonomous while being supported in their physical, emotional, social, cognitive and spiritual needs. ...The Eden's Vision is to eliminate loneliness, helplessness and boredom.	F 679		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700		2/16/24

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F 700	Continued From page 4 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure bed rails were assessed for entrapment risk for 1 of 3 sample residents (#27). The findings were: 1. Review of the quarterly MDS assessment dated 11/15/23 showed resident #27 had short-term and long-term memory problems and diagnoses which included cerebrovascular accident, seizure disorder or epilepsy, depression, difficulty in walking, muscle weakness, and pain. Further review showed the resident required supervision or touching assistance for chair/bed-to-chair transfers and rolling left and right, and required partial/moderate assistance for sitting to standing. Review of the resident's care plan last revised on 10/23/23 showed the resident was high risk for falls related to a history of left hip fracture, weakness, bilateral lower extremity weakness, effects of 2 CVAs, seizure disorder psychotropic drug use, and routinely refusing to talk to others. The following concerns were identified: a. Observation on 1/17/24 at 9:42 AM showed the resident was lying in bed and a quarter bed rail was in the upright and locked position, to the side of the bed which was not against the wall. The bed rail was designed with 2 gaps and the bed controls were fixed to the rail. b. Observation on 1/18/24 at 9:39 AM showed the resident was lying in bed and a quarter bed rail was in the upright and locked position, to the side of the bed which was not against the wall. c. Observation on 1/18/24 at 1:36 PM showed the resident was lying in bed and a quarter bed	F 700	Resident #24 was immediately assessed for a bed entrapment risk. All residents with bedrails charts were audited to ensure that risk assessment had been completed. All residents with bedrails engaged have the potential to be affected. All nurses will be educated on bed entrapment assessments to ensure entrapment risk assessment have been completed as required. The Director of Nursing and or designee will conduct monthly audits of assessments to ensure proper practice. Audits findings will be presented to the QUAPI team quarterly and assessed. The team will review and make recommendations. The Director of Nursing is responsible for the tag and reporting.	

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F 700	Continued From page 5	F 700		

rail was in the upright and locked position, to the side of the bed which was not against the wall.

d. Review of the medical record showed no evidence the bed rail had been assessed for entrapment risk.

e. Interview with the clinical vice president on 1/18/24 at 2:40 PM confirmed the bed rail had not been assessed for entrapment risk and revealed the bed rail had to be in place due to the bed controls being permanently attached to the bed rail.

f. Observation of the bed rail with the clinical vice president on 1/19/24 at 8:16 AM showed the bed rail gaps each measured 5 1/4 inches high by 6 1/4 inches wide. Interview with the clinical vice president at that time confirmed the gaps were large enough for a resident to get a limb through and should be assessed for entrapment risk.

2. Review of the policy titled "Bed Safety" last revised on 10/2017 showed "...2. To try to prevent deaths/injuries from beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapmentrisks [sic]; b. Review the gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight movement or bed position); c. Ensure that when bed system components are worn and need to be replaced, components meet manufacturer's specifications; d. Ensure that bed side rails are properly installed using manufacturer's instructions and other pertinent safety guidance to ensure proper fit

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F 700	Continued From page 6 (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.)...4. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment..."	F 700		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure behavioral health services were provided to 1 of 3 sample residents (#13) with a psychiatric diagnosis. The findings were: 1. Review of the quarterly MDS assessment dated 10/23/23 showed resident #13 had diagnoses which included schizophrenia (e.g., schizoeffective and schizophreniform disorders) and a brief interview for mental status score of 12 out of 15, which indicated the resident was	F 740	Resident #13 was immediately assessed by floor nurse and Social Services Director and offered counseling services to which she agreed. An appointment was made on 1/22/2024 of which the resident did attend. All residents with PASRR II whom exhibit signs of emotional/psychological distress will have the potential to be affected. All residents with a PASRR II's charts	2/16/24

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F 740	Continued From page 7 cognitively intact. Further review showed the resident received antipsychotic medication and antidepressant medication, and the last gradual dose reduction was clinically contraindicated by the physician on 10/18/23. Review of the care plan last revised on 7/31/23 showed the resident had impaired cognitive function related to impaired thought processes, impaired decision making, short term memory loss, pain, effect of diabetes,and schizoaffective disorder. Interventions included psychiatric consult as indicated. The following concerns were identified: a. Review of the annual MDS assessment dated 12/29/21 showed the resident had diagnoses which included other specified mental disorders due to brain damage and dysfunction and to physical disease; however, there was no indication the resident had a diagnosis of schizoeffective disorder or schizophrenia. Review of the 11/21/22 annual MDS assessment showed the resident had diagnoses which included schizophrenia (e.g., schizoeffective and schizophreniform disorders), while a resident at the facility. b. Review of a "PASRR II Evaluation" dated 11/27/23 showed the resident was "...recently diagnosed with schizoaffective disorder, unspecified and required a PASRR II..." Further review showed recommendations included specialized services for mental illness and a neurocognitive evaluation. c. Review of the medical record showed no evidence the resident received mental health services or a neurocognitive evaluation was completed. d. Interview with the resident's physician on 1/18/24 at 10:27 AM confirmed the resident had not received any outside psychiatric services due to the last time it was attempted, the resident had	F 740	have been audited to ensure that behavioral health care and services are offered to attain and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Social Services Director was educated on proper follow up of behavioral health services to ensure residents are routinely offered therapy services. The Director of Nursing and or designee will conduct monthly audits of residents with PASSR II to ensure proper practice. Audits findings will be presented to the QUAPI team quarterly and assessed. The team will review and make recommendations. The Director of Nursing is responsible for the tag and reporting.	

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F 740	Continued From page 8 a bad experience. Further interview revealed the physician felt psychiatric services would be beneficial to the resident and telehealth may be an option. e. Interview with the clinical vice president and social services director on 1/18/24 at 2:56 PM revealed the resident did not like going outside and that was the reason s/he was not going to mental health services outside the facility. They confirmed mental health services would benefit the resident and they were unsure if the telehealth was an option. Further interview confirmed the resident had not received mental health services since s/he received the schizoeffective disorder diagnoses. 2. Review of the policy titled "Behavioral Health Services" dated June 2023 showed "...1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. 2. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care..."	F 740		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		2/16/24

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F 761	Continued From page 9 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and professional standard review, the facility failed to ensure medications were labeled in accordance with professional standards in 1 of 3 medication storage units (back hall medication cart). The findings were: 1. Observation on 1/17/24 at 1:52 PM of the back hall medication cart, showed 1 Humalog 100 unit/ml vial with no open date, and 1 Humalog 100 unit/ml Kwik pen dated 11/29/23. Interview at that time with MA-C #1 confirmed the medications were for resident use. Further, the MA stated the medication should be dated when opened. She confirmed the insulins should only be used for 28 days or 1 month. 2. Interview with the clinical vice president on 1/17/24 at 2:44 PM revealed insulins should be labeled with the date opened, when it was removed from the refrigerator. Further interview confirmed insulin vials were good for 28 days	F 761	The expired insulin was thrown out. All residents receiving insulin have the potential to be affected. All nurses will be educated on management of insulin and expiration dates of all medications. The Director of Nursing and or designee will conduct weekly audits of insulin dates and all other medication dates to ensure proper practice. Audits findings will be presented to the QUAPI team quarterly and assessed. The team will review and make recommendations. The Director of Nursing is responsible for the tag and reporting.	

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F 761	Continued From page 10 after being removed from the refrigerator. 3. Review of the policy "Medication Labeling and Storage" last reviewed June 2023 showed "...3. If the facility has discontinued, outdated or deteriorated medications or biological's, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. ...5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial." 4. Review of the Food and Drug Administration (FDA) web page titled "Information Regarding Insulin Storage and Switching Between Products in an Emergency" accessed 1/22/24 showed "...Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°Fahrenheit (F) and 86°F for up to 28 days and continue to work. However, an insulin product that has been altered for the purpose of dilution or by removal from the manufacturer's original vial should be discarded within two weeks."	F 761		