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 03/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/20/24 to 3/21/24. The survey was prompted by complaint intakes WY000003781, WY000003804, and WY000003826. The following common abbreviations are used throughout this document: ADL: Activites of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nurse Assistant MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure residents received necessary services to maintain good personal hygiene for 2 of 5 sample residents (#1, #3). The findings were: 1. Review of the quarterly MDS assessment dated 12/23/23 showed resident #1 had a BIMS score of 9 out of 15 (moderately cognitive	F 677	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity	5/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 677	Continued From page 1 impairment), and required extensive assistance with mobility, dressing, toileting, and hygiene. Review of the care plan last revised on 1/26/24 showed the resident had ADL self-care performance deficit and needed assistance with self care tasks that included bathing. The resident preferred showers on Tuesdays and Fridays. The following concerns were identified: a. Review of January 2024 bathing record showed from 1/19/24 through 1/26/24 the resident went 5 days without a bath/shower. On 1/23/24 the staff marked the bath/shower as "Not Applicable". b. Review of February 2024 bathing record showed from 1/30/24 through 2/9/24 the resident went 9 days without a bath/shower. On 2/2/24 and 2/6/24 the staff marked the bath/shower as "Not Applicable". c. Review of March 2024 bathing record showed from 3/14/24 through 3/20/24 the resident went 5 days without a bath/shower. The staff had marked on 3/15/24 and 3/19/24 as "Not Applicable". d. Review of the facility incident report dated 1/18/24 at 1:45 PM showed resident #1 was in a poor state of hygiene, and the resident's legs were dirty when taken to a doctor's appointment. e. Interview with the resident on 3/20/24 at 10:10 AM revealed the staff do not give him/her showers like they are suppose to. 2. Review of the annual MDS assessment dated 1/19/24 showed resident #3 had a BIMS score of 15 out of 15 (cognitively intact), and required substantial/maximal assistance with toileting, showers, upper and lower body dressing. Review of the ADL bathing/shower record showed the resident preferred bathing/showers on Mondays and Wednesdays. The following concerns were	F 677	regarding the deficiencies cited are correctly applied. F677- ADL Care Problem: The facility failed to ensure residents received necessary services to maintain good personal hygiene for residents (#1 #3). 1) Corrective Action: A) Resident #1 received the necessary services to maintain hygiene, specifically assistance in bathing. Resident #1 received a shower on 3/22/24 and resident preference. CNA #1 education started on 4/12/24 by DON/ designee about providing baths/showers on the day scheduled. Resident #3 no longer resides in the facility. 2) Identification of Others: A) All other ADL dependent residents bathing schedules audits started 4/12/24 and completed by date of compliance. Each shift CNA staff receives a bathing list for their assignment to complete within the shift. A facility wide audit started on 4/12/24 and completed by the date of compliance to ensure bathing schedules were met. Education started on 4/12/24 and completed by date of compliance to all nursing staff regarding providing showers on day scheduled and what to do when a resident refuses on or prior to date of alleged compliance by the DON or designee. 3) Systemic Changes: A) The DON/ designee will educate all nursing staff starting on 4/12/24, upon hire, upon returning from leave, annually and as needed regarding providing	

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F 677	Continued From page 2 identified: a. Review of February 2024 bathing record showed from 2/1/24 through 2/12/24 the resident went 10 days without a bath/shower with a "Not Applicable" on 2/5/24. b. Interview with resident's #3 family member on 3/21/24 at 12:07 PM revealed she had talked to the facility multiple times related to the resident not getting his/her baths. She stated she was very unhappy about the resident not getting his/her baths when s/he was supposed to. 3. Interview with CNA #1 on 3/20/24 at 10 AM revealed the CNAs try to get the residents their baths on the days they are due. There are times they just can't always get them done. 4. Review of the policy "Resident Showers" implementation date 8/1/23 showed "...Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. " 5. Review of the "AD HOC QAPI" dated 1/19/24 showed "Introduction of new Performance Improvement Plans. ADL Bathing-goal increased completion/compliance of showers for neighbors."	F 677	bathing tasks as the resident prefers that meets the requirements of this regulation. 4) Monitoring: A) DON/ designee will do random audits 2 times a week for one month, then weekly for one month, then monthly for one month and as needed, for a minimum of 12 weeks. Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. 5) Date of alleged compliance: May 3, 2024.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		5/3/24

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F 684	Continued From page 3 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and compliant investigation review, the facility failed to ensure residents received care according to professional standards for 1 of 5 sample residents (#1). The findings were: 1. Review of the quarterly MDS assessment dated 12/23/23 showed resident #1 had a BIMS score of 9 out of 15 (moderately cognitive impairment), and required extensive assistance with mobility, dressing, toileting, and hygiene. Diagnoses included Diabetes Mellitus, depression, chronic inflammatory demyelinating polyneuritis, cirrhosis of liver, muscle weakness lipodystrophy, secondary throbocytopenia. The following concerns were identified: a. Review of the physician orders showed start date of 9/1/20 for Blood Sugar (BS) over 400 milligrams per deciliter (mg/dl) call medical director (MD). Below 60 mg/dl call MD. b. Review of the January 2024 medication administration record showed on 1/18/24 at 10:39 AM the BS reading was 452. c. Review of the progress notes failed to show the MD was notified of the elevated BS on 1/18/24. Further review showed on 1/18/24 at 10:37 AM the resident went to appointment with an endocrinologist and the residents BS was 400 in the office. 2. Interview with with RN #1 on 3/20/24 at 9:50 AM revealed if a resident's BS is elevated at 400 or greater, we would call the doctor. 3. Interview with the administrator on 3/20/24 at 8:59 AM revealed it is the facility's expectation for	F 684	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F684 Problem: The facility failed to ensure residents received care according to professional standards for 1 resident (#1) regarding notifying the physician related to abnormal blood glucose levels. 1) Corrective Action: A) Resident #1 physician notified on 4/11/2024 of abnormal blood glucose level. Facility wide audit started 4/12/24 and to be completed by date of compliance on residents with diabetic parameters and no further issues found. 2) Identification of Others: A) All residents that reside at Casper Mountain Rehabilitation Center that require blood glucose monitoring are at risk. Facility wide audit started 4/12/24 and completed by date of compliance for residents with diabetic parameters to ensure regulations were met. 3) Systemic Changes: A) The DON/ designee will educate all	

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F 684	Continued From page 4 nursing staff to follow the physician's orders.	F 684	nurses and medication aides starting 4/12/24 and completed by date of compliance regarding physician parameter notification when blood glucose levels are abnormal (per physician orders). 4) Monitoring: A) An audit started on 4/12/24 will be completed by date of compliance for all diabetic residents for the last thirty days to ensure physicians were notified of abnormal levels. Audits will be conducted 2 times a week for 4 weeks, then weekly times 4 weeks and monthly thereafter, and as needed to ensure physicians are being notified of abnormal levels to meet this regulation. Any issues will be tracked and trended. DON/designee will report the results to QAPI monthly as needed to assure the plan is implemented, sustained, and evaluated for its effectiveness until substantial compliance is met. 5) Date of alleged compliance: May 3, 2024	