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 01/15/2025

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 investigation was performed on 1/14/25 to 1/15/25. The survey was prompted by complaints WY00003970, WY00003965, WY00003979, WY00004075, WY00004095, WY00004111 and WY00004154. The following common abbreviations are used throughout this document: MDS: Minimum Data Set BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant ADL: Activities of Daily Living .	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		2/21/25

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

Electronically Signed | 02/07/2025

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 585	Continued From page 1 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 585		

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F 585	Continued From page 2 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident representative and staff interview, review of grievance logs, and policy and procedure review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 4 sample residents (#1). The following concerns were	F 585	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the	

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F 585	Continued From page 3 identified: 1. Review of the quarterly minimum data set (MDS) assessment dated 12/29/24 showed resident #1 had a brief interview for mental status (BIMS) score of 10 out of 15, which indicated s/he had moderately impaired cognition, and diagnoses which included Alzheimer's dementia. The social services assessment note dated 8/5/24 showed the residents hearing was marked as "highly impaired." 2. Review of a care conference note dated 9/14/23 showed resident #1's family had voiced concerns about his/her missing hearing aids. 3. Review of facility grievance logs showed no further documentation in relation to the missing hearing aids. 4. Review of the care plan last updated 1/12/25 showed the resident had difficulty hearing related to advanced age. Further review showed the intervention was to ensure hearing aid(s) were in place. 5. Review of the resident's medical record and activity of daily living (ADL) tasks performed by the CNAs dated 12/16/24 to 1/14/24 showed the resident was marked as "not owning hearing aids." 6. Interview with the resident's representative on 1/14/25 at 4:25 PM revealed the resident's hearing aids had been missing for 2 years, and the family did not know they should fill out a grievance form. Further interview revealed they had verbally told the staff in every care plan meeting "at least every 2 months for the last 2	F 585	conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community□s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. 1. CORRECTIVE ACTION The meeting was held on February 7, 2025, with Resident #1 family to review the concern resolutions were: A. review of grievance procedure with Family for any future concerns, and how to ensure management is aware of those issues and follow up with any other concerns they may have. B. belonging have now been inventoried C. resident has an audiology appointment scheduled for February 24, 2025. If determined there is still a need for hearing aids, Casper Mountain Rehabilitation will	

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F 585	Continued From page 4 years" that the resident's hearing aids had been missing, and nothing was ever done to locate or replace them. 7. Interview with the administrator on 1/15/25 at 10:40 AM revealed it was the first he had heard of missing hearing aids and he was going to follow up with the social services director (SSD). 8. Interview with the SSD on 1/15/25 at 11:50 AM revealed he was unaware of any missing hearing aids, and if it had come up with the family it would have been in a care conference with the previous SSD last September. Further interview revealed the protocol to locate missing items would be that a grievance form was filled out by a resident's family or direct care staff and then given to him for follow up. 9. Interview with medication aide #1 on 1/15/25 at 3:03 PM revealed he had never seen the resident wear hearing aids in the 6 years he provided care to the resident. 10. Interview with the administrator on 1/15/25 at 4:10 PM revealed he was unable to find an inventory of the resident's belongings that would have been taken on admission to the facility. 11. Observation of the resident on 1/15/25 at 3 PM showed the resident was not wearing hearing aids. 12. Review of the policy titled "Resident and Family Grievances" last reviewed on 5/21/24 showed "... 4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished... 8.	F 585	purchase these devices to replace the ones not found. D. Care Plan updated to note resident□s status and will be again updated after appointment. E. Physician made aware February 6, 2025, and documented. II. How to identify other residents A. 100% audit done on February 5th, 2025, by Nursing Home Administrator, (NHA)/designee in the community to ensure residents have an inventory of personal belongings B. The audit included updating inventory sheets when residents get new items. C. An audit of the past 30 days of grievances will be completed by February 14, 2025, by NHA/designee. The audit will look for resolution of concerns and the community will pull random grievances in the past 30 days to ensure resolution with the reporting grievance person. III. Systemic changes A. Training staff about the importance of detailed inventory sheets will be completed on February 20, 2024, by Director of Marketing and Admissions/designee B. Training with re-education of staff	

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F 585	Continued From page 5 Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. ...d. Verbal complaint during resident or family council meetings...10. b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations... 12. The facility will make prompt efforts to resolve grievances."	F 585	on the grievance procedure will be completed by February 20, 2024, by NHA/Designee. This will include the importance of completing grievance when they hear a concern from family and neighbors, regardless of how it is reported, and review of the Grievance Policy. This will include the importance of completing grievance when they hear a concern from family and residents, regardless of how it is reported. C. Management training will be completed by February 14, 2025, by NHA/Designee to ensure that grievances are being completed during care conferences and any other meeting where concerns are brought to their attention. IV, Monitoring Process Weekly audits will be done for the next four weeks to ensure all new admissions have inventory sheets by NHA/designee. The Social Services Director/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		2/21/25

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F 656	Continued From page 6 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 7 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was implemented for 1 of 3 sample residents (#1) reviewed for care plans. The findings were: 1. Review of the quarterly MDS assessment dated 12/29/24 showed resident #1 had a BIMS score of 10 out of 15, which indicated s/he had moderately impaired cognition, and diagnoses which included Alzheimer's dementia. The social services assessment note dated 8/5/24 showed the resident's hearing was marked as "highly impaired." 2. Review of the care plan last updated 1/12/25 showed the resident had difficulty hearing related to advanced age. Further review showed the intervention was to ensure hearing aid(s) were in place. 3. Review of the resident's medical record and ADL tasks performed by the CNA staff dated 12/16/24 to 1/14/24 showed the resident was marked as "not owning hearing aids." 4. Observation of the resident on 1/15/25 at 3 PM showed s/he was not wearing hearing aids. 5. Interview with medication aide #1 on 1/15/25 at 3:03 PM revealed he had never seen the	F 656	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. I. CORRECTIVE ACTION A care conference is set up for February 7, 2025, to go over Resident #1	

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F 656	Continued From page 8 resident wear hearing aids in the 6 years he provided care to the resident. He stated the expectation was that the CNAs documented in the chart if a resident wore hearing aids. 6. Interview with the administrator on 1/15/25 at 4:10 PM revealed he was unable to find an inventory of the resident's belongings that were taken upon admission to the facility. He confirmed the resident had not been wearing hearing aids.	F 656	current care plan. o Care plan for Resident #1 will be updated to accurately reflect their current medical conditions, preferences, and goals. o Resident#1 and their responsible party will be included to ensure their input in the care plan. o Any Care plan updates will have interdisciplinary team (IDT) members involved to ensure proper implementation. II. IDENTIFIED OTHER RESIDENTS 100% audit will be conducted on February 14, 2025 by Director of Nurses/designee to review care plans for current residents to ensure compliance with regulatory requirements. · Deficiencies identified during the audit will be corrected immediately and care plans will be updated accordingly by the Interdisciplinary Team. · Special attention was given to residents with new diagnoses, changes in condition, behavioral concerns, adaptive devices and specific care needs to ensure their plans were comprehensive. III. SYSTEMIC CHANGES interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing Comprehensive Care Plans by February 20, 2025 by MDS Specialist. The training will also include: · Timely initiation and updates of person-centered care plans	

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F 656	Continued From page 9	F 656	· Ensuring input from residents, families, and all relevant departments · Monitoring for changes in residents' needs and revising care plans accordingly IV. MONITORING Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator/designee. Each care plan will be updated as indicated. The Director of Nursing/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	