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 04/02/2025

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 3/30/25 through 4/2/25. Also reviewed in the course of the survey were complaint intakes WY00004049 and WY00004164. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status MDS: Minimum Data Sheet Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	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- §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 staff interview, medical record review,	F 600	Past noncompliance: no plan of	

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

Electronically Signed | 04/25/2025

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F 600	Continued From page 1	F 600		

facility incident investigation review, state survey agency incident database review, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 6 sample residents (#45) reviewed for physical abuse. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 1/15/25. The findings were:

1. Review of the 3/1/25 quarterly MDS assessment for resident #22 showed s/he had a BIMS score of 00 out of 15 (severe cognitive impairment) and diagnoses which included sequelae of cerebral infarction, seizure disorder, depression white matter disease, and cognitive communication deficit. The resident had physical and verbal behaviors towards others, and wandered during the 7-day look-back period. Review of the care plan, last revised 1/6/25, showed "Resident exhibits/at risk for behaviors such as refusals, aggression, agitation, spitting, scratching, hitting, and exit seeking." The interventions included "Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes." The following concerns were identified:

a. Review of a facility incident investigation showed resident #45 was being pushed down the hall by family on 12/30/24 when resident #22 hit him/her on the head. The residents were immediately separated. Resident #45 was assessed for injury and none were noted. The

correction required.

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F 600	Continued From page 2	F 600		

facility monitored resident #22 with a one-on-one to ensure other residents were safe. Resident #22 had a history of agitation and aggression. The facility had been able to correlate previous behaviors with urinary tract infections, abnormal labs, pain, or imbalances in the past. The facility ordered a urinalysis. a complete blood count, and a comprehensive metabolic panel. Resident #22 was found to have a urinary tract infection and was treated for it. Further review showed the facility determined physical abuse occurred and substantiated the allegation.

b. Due to resident #22's cognitive status s/he was unable to be interviewed. Resident #45 expired on 1/4/25.

c. Review of the state survey agency incident database showed on 12/30/24 at 5:56 PM the facility reported that resident #45 was hit on the head by resident #22. Further review showed resident #45 was crying after being hit.

2. Interview with the ADON on 3/31/25 at 2:06 PM confirmed resident #45 did cry out after being hit and resident #22 was placed on 1-to-1 monitoring, with 15-minute checks. Further interview revealed the facility implemented behavior monitoring, staff education, weekly audits on all residents which were reviewed in the quality assurance meeting, and referrals for alternate placement of resident #22.

3. Review of the 1/6/25 social services notes showed the social service director had sent referrals to two skilled nursing facilities for potential transfer related to behaviors of resident #22.

4. Review of the policy "Preventing Resident to Resident Abuse" dated 12/13/24 showed "1.

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F 600	Continued From page 3 Residents with a history of physical and or verbal abuse of other persons will be evaluated prior to admission to ensure that this Community has the services the resident needs to achieve their highest practicable level of functioning and to protect other residents from harm. 2. Each resident who has a history of physical and/or verbal abuse of other persons will be evaluated to determine the appropriate interventions to prevent behaviors that could adversely affect other residents." 5. Review and verification of the facility's corrective action plan showed: a. Both residents were immediately assessed and placed on monitoring. b. Staff education was performed on 1/15/25. c. 15 minute checks were implemented. d. Weekly audits were performed on all residents. e. Audits were reviewed in the quality assurance committee meeting.	F 600		
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 a minimum, the following elements:	F 880		5/23/25

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F 880	Continued From page 4 §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 §483.71 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		

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F 880	Continued From page 5 §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, review of CDC guidelines, and staff interview, the facility failed to ensure effective infection control practices were followed during 1 random observation. The findings were: 1. Observation on 4/2/25 at 9:45 AM of the laundry room showed cloth gowns were used to sort contaminated laundry. Drops of water were placed on the gown by the ADON which showed the gowns were not fluid resistant. The ADON confirmed the gowns were not fluid resistant and discarded them at that time. 2. According to the CDC guidelines located at https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html#cdc_generic_section_6-6-surgical-gowns-drapes-and-disposable-fabrics, accessed on 4/8/25, showed "...6. Surgical Gowns, Drapes, and Disposable Fabrics...Regardless of the material used to manufacture gowns and drapes, these items must be resistant to liquid and microbial penetration..."	F 880	F880 Infection Prevention and Control The facility failed to ensure effective infection control practices in the laundry room. Cloth gowns were used in the laundry room to sort contaminated laundry. The gowns were not fluid resistant, which failed to meet the standard of transmission based precautions. Cloth gowns were immediately discarded and water resistant gowns were supplied and placed so they are readily available, deficiency was corrected real time. Staff members (specifically maintenance director and laundry personnel) were educated regarding appropriate gowns to be used for infection control-"always use water resistant gowns when coming into contact with soiled or contaminated laundry". Will continue to provide ongoing	

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F 880	Continued From page 6	F 880	education to include wearing water resistant gowns when handling soiled or contaminated laundry. Audits to be completed by housekeeping supervisor or designated staff member to ensure water resistant gowns are being used when handling soiled or contaminated laundry. Weekly audits will be completed of laundry staff for four weeks to ensure proper PPE use is maintained until routine is established and compliance met, then may move to random audit. Audit findings will be reviewed during QA committee monthly for further review and recommendations.	