STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 6/11/25 to 6/27/25. The survey was prompted by complaints WY00004348, WY00004360, WY00004377, WY00004437, and WY00004438. The following common abbreviations are used throughout this document: MDS: Minimum Data Set BIMS: Brief Interview for Mental Status ED: Executive Director SSD: Social Services Director RN: Registered Nurse POA: Power of Attorney DNS: Director of Nursing Services ER: Emergency Room EMS: Emergency Medical Services Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is	F 627		6/27/25

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

Electronically Signed | 07/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 1	F 627		

endangered due to the clinical or behavioral status of the resident;
(D)The health of individuals in the facility would otherwise be endangered;
(E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F)The facility ceases to operate.

§483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 2 institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous	F 627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 3	F 627		

room if available or immediately upon the first availability of a bed in a semi-private room if the resident-
(A) Requires the services provided by the facility; and
(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services
(ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 4	F 627		

resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 5 provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident	F 627	Immediate Action:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 6 representative, hospital staff and staff interview the facility failed to ensure a resident was allowed to return following a transfer to an acute care setting for 1 of 3 sample residents (#1) reviewed for discharge. The findings were: 1. Review of the medical record for resident #1 showed the resident was admitted to the facility on 4/1/25. Review of the admission MDS assessment dated 4/1/25 showed resident #1 was unable to complete a BIMS assessment, had severely impaired cognitive skills for daily decision making, and diagnoses which included non-Alzheimer's dementia, Pick's disease, other frontotemporal neurocognitive disorder, and aphasia. Further review of the medical record showed resident #1 had behavioral issues, which included wandering through the hallways and other resident rooms, defecating and urinating in the hallway, and physical aggression toward other residents and staff. The following concerns were identified: a. Review of a progress note dated 4/1/25 and timed 1:35 PM showed "Late entry: While RN was completing resident's admission with [his/her] sister/POA, [name], she stated that resident has regressed quite a bit since [his/her] last stay here. She reported [s/he] was voiding and defecating in inappropriate places, often hypersexual, aggressive, and has not been bathed in 4 months due to her not wanting to fight with [him/her] to take a shower. RN reported this to [name], SSD, and [name], ED, as I felt as if these things were concerning with accepting this admission. This RN witnessed [SSD] enter the resident's room and tell [sister] that we will take resident on a trial basis, however if resident proves too much for our staff to handle or it doesn't work out we will send out referrals to get	F 627	The resident is discharged. ID of others: DON/designee to perform an audit of facility-initiated discharges of the past 3 months for appropriate documentation. Systemic Changes: A weekly audit of facility-initiated discharges from the center will be reviewed by the DON/social services or designee x 8 weeks, then monthly for 1 month, to validate residents are allowed to return following a transfer to acute care setting. The administrator provided education to nurses, SSD, Admissions and BOM regarding facility initiated discharges. Monitoring: DON or designee will report the tracking and trending of the audits to the monthly QAPI for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 7	F 627		

[him/her] to a more secure locked unit, however she would need to come pick [him/her] up."

b. Review of a progress note dated 4/7/25 and timed 7:11 PM showed "Spoke with sister [name] at length regarding placement to a locked unit. We have not been successful at this time. She is distraught and afraid [s/he] will be placed far away. She is teary and concerned. We assured her that we will do everything we can for [him/her] and her. She gave some insight into some activities [s/he] does enjoy..."

c. Review of a progress note dated 5/28/25 and timed 2:36 PM showed referrals were sent to 10 care centers by the SSD.

d. Review of a progress note dated 5/28/25 and timed 3 PM showed "DNS [name] informed RN that we are to send resident to [hospital] ER for aggression via ambulance at this time. She completed the ER transport form. 911 called to request EMS. Report called to [name] in the ER. Dr. [name] notified via phone of transport by this RN at 3:37 PM. Resident admitted to Med Surg 3rd floor per RN from [hospital name] who called with a medication question."

e. Review of a progress note dated 5/28/25 and timed 5:35 PM showed "SSD called [name] and let her know resident was sent to the ER @ [hospital name] again today. The connection was bad and SSD made sure [name] could hear me when speaking. SSD informed [name] resident was sent out and [facility] would not be accepting [him/her] back. [name] told SSDit [sic] is my responsibility to find [him/her] placement. SSD let [name] know I have a list of places that may accept him/her and s/he is on the waiting list for [facility]. The call was dropped at this time [sic] [name] called back and SSD answered the phone. [Name] asked if I meant to hang up on her and I explained I did not. SSD asked if she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 8	F 627		

heard the last information on the places that may be willing to take resident. [Name] had not heard me? (she was driving in a rain storm near [name of town] where the service is spotty)[sic] [name] said she did not and began to repeat herself about it being [facility's] responsibility to find [him/her] placement. SSD let [name] know this decision came from cooperate [sic] and gave her [name of corporate staff] name to follow up with. SSD apologized and told her it was not a choice we here made and the safety of the other residents and staff had to be considered. [Name] said she did not disagree with [facility] not keeping resident. SSD then told her again I have a list of places that may accepthim [sic] and spoke to her directly about [list of 3 facilities]. [Name] thanked SSD and asked if there were any places in [2 cities]. SSD let her know I was not able to locate any. SSD offered to provide [name] with a list of places I have sent referrals to... SSD told [name] we will get residents belongings packed up and if she wants to let us know when she is in town we will make sure they are all ready for her along with th4 [sic] list of places ho [sic] may be willing to accept resident. SSD explained the hope was to find a place to transfer [him/her]. [Name] thanked SSD and said she will let us know when she is able to come pick up [his/her] things."

f. Review of a "Resident Notice of Transfer or Discharge" dated 5/28/25 showed the reason for transfer/discharge was "The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility." Further review showed "You have the right to appeal this decision" and the resident's representative was notified by phone.

g. Review of a letter written by the ED, dated 5/28/25 and addressed to the resident's sister

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 9	F 627		

showed "This letter will serve as formal notification that it is the intention of Rawlins Rehabilitation and Wellness to discharge [name] on 6/29/25 due to [his/her] clinical or behavioral status endangers the safety of self and individuals in the facility and the physician also supports this discharge. As discussed upon admission, [facility name] would admit [name] on a trial to see if [his/her]needs and behavioral status could be met at the center. This has been an ongoing situation that the facility has attempted to reconcile on numerous occasions. You are encouraged to contact Social Services to give appropriate instructions of the location where you desire [name] to be discharged. In the absence of alternative instructions, [name] will be discharged to the custody of you...."

h. Interview with the ED on 6/12/25 at 8:40 AM revealed resident #1 had been at the facility prior to the 4/1/25 admission, and when the resident's sister had asked if the facility would take him/her back, she neglected to tell them s/he had increased behaviors. She reported the facility staff asked his/her sister if she would be able to take him/her back home if the facility could not provide the care s/he needed and she said yes, however that changed when the behaviors got worse. She stated the doctor had reported the resident had "more going on than Pick's disease" and his/her behaviors could change hourly, which was why a medication might work one day and not the next.

i. Interview with the resident's sister on 6/12/25 at 8:54 AM revealed the facility did not secure a different facility for the resident and "dumped" the resident at the hospital on 5/28/25 where s/he was put on a Title 25 hold in a "metal cell" before the hospital secured placement out of state at a short-term psychiatric facility. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 10	F 627		

reported the current out of state facility was trying to find in-state placement, and that was difficult because no facilities in the state were accepting the resident.

j. Interview with the hospital social worker on 6/12/25 at 2:48 PM revealed she received an email from the SSD on 5/28/25 at 6:10 PM with a list of 3 places that were willing to accept the resident, and 2 of them were out of state. She contacted the resident's sister who did not want to move the resident to the assisted living facility out of state because it was private pay, and stated when she contacted the in-state facility, they informed her the resident was not appropriate for the facility and was not on the waiting list. The third facility was an out of state psychiatric facility but did not have any openings at first, and told the social worker that she should call frequently to check if they had an opening. Further interview revealed she did not receive any further communication from the facility, she called the third facility frequently as they had suggested, and she was able to place the resident at that facility for short term psychiatric rehabilitation.

k. Interview with the SSD on 6/12/25 at 4:00 PM revealed when she learned of the resident's increased behaviors and aggression toward others, she let the resident's sister know they would do a 30-day trial and if they could not manage the resident's behaviors, she would need to agree to take him/her back home, which the SSD reported she did. She reported she sent many referrals and was either told the resident would not be accepted by the facility or did not receive a response. Further interview revealed on 5/28/25 the resident choked a CNA and hit a nurse, and was sent to the hospital for adjustments to his/her medications. She confirmed she called the resident's sister to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 627	Continued From page 11	F 627		

inform her of the assaults and that the facility would not be able to take the resident back. She reported she found 3 places that would possibly accept the resident, and that she had emailed the social worker at the hospital the list of facilities. Further interview confirmed she was not in contact with the hospital and did not know where the resident had been discharged. She reported the hospital social worker had picked up the resident's belongings.

l. Interview with the ED on 6/12/25 at 4:50 PM revealed while s/he was in the facility, the resident had injured CNAs and 1 had been sent to the ER. She reported the facility staff had tried multiple interventions and the behaviors had continued. She reported the rooms at the hospital were "open window psych rooms" where the nurse could get in to assist and the resident could not get out.

m. During an interview on 6/27/25 at 10:03 AM the hospital social worker stated when the patient was sent to the hospital the nurse from the facility called and stated the resident had been aggressive and hit staff. The nurse told the hospital they were not taking the resident back. The social worker further stated the facility never called to arrange a time to evaluate the patient to see if s/he was appropriate to return to the nursing home. The patient was discharged from the hospital on 6/3/25.