STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , Casper, Wyoming, 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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/24/25 to 8/27/25. Also reviewed in the course of the survey were complaint intakes 1901829, 2565697, 2580838, 2580868, 2588806, 2589559, 2597424, 2597451, and 2600228. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Sheet NHA: Nursing Home Administrator RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/24/2025
F0553 SS = E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F0553	F0553 – The Right to Participate in Planning Care This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be inadmissible in any proceeding on that	10/05/2025

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 reverse for further 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.

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

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F0553 SS = E	Continued from page 1 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to include residents in the care planning process for 3 of 5 sample residents (#12, #30, #84) reviewed. The findings were: 1. Review of the 7/17/25 annual MDS assessment showed resident #12 was admitted to the facility on 1/27/22 and had a BIMS score of 15 out of 15 (cognitively intact). Further review showed the resident had a quarterly MDS assessment completed on 9/30/24, 12/31/24, and 4/2/25. The following concerns were identified: a. Interview with the resident on 8/24/25 at 3:47 PM revealed s/he did not recall being invited to a care conference meeting. b. Review of the resident's medical record showed the last documented care conference was held on 5/9/23. 2. Review of the quarterly MDS assessment showed resident #84 was admitted to the facility on 3/17/25	F0553	Continued from page 1 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. Corrective Action for Affected Residents: On 09/18/25, Residents #12, #30, and #84 were invited to participate in care conferences. The MDS Coordinator or Designee will review their care plans with each resident on their designated day, to obtain their input and preferences, and document their participation. Care conferences were held with these residents by 09/26/25, and their care plans will be updated to reflect their choices and preferences. Identifying other Residents having the Potential to be Affected: On 8/26/25, the DON or designee conducted an audit of resident medical records to identify residents who had not participated in a care conference within the past quarter. Residents identified through this audit were offered care conferences and provided dates for their next scheduled conferences. Measures put into place or Systemic Changes: The DON or designee in-serviced the Interdisciplinary Care (IDC) team on 8/27/25 regarding resident rights to participate in care planning, including: - Requirements for quarterly care conferences - Process for scheduling care conferences at times convenient for residents - Documentation requirements for resident participation - Obtaining resident signatures after significant care plan changes - Procedure for inviting residents to subsequent care conferences during current care conference The User Defined Assessment (UDA) "Care Conference Summary" has been scheduled for residents and will trigger every 84 days to ensure staff are reminded of the due date. The Social Services Director, or designee will maintain a care conference calendar to track scheduled conferences and resident participation.	

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F0553 SS = E	Continued from page 2 and had a BIMS score of 15 out of 15 (cognitively intact). The following concerns were identified: a. Interview with the resident on 8/25/25 at 9:27 AM revealed s/he had not been invited to a care conference meeting. b. Review of the resident's medical record showed the last documented care conference was held on 3/25/25. c. Review of the resident's care plan showed it was last revised on 6/30/25. 3. Review of the review of the comprehensive MDS assessment dated 7/28/25 showed resident #30 was initially admitted to the facility on 3/1/21, with the most recent reentry date of 8/26/23. Further review showed the resident had a BIMS score of 15 out of 15 (cognitively intact). The following concerns were identified: a. Interview with the resident on 8/25/25 at 9:50 AM revealed s/he recalled only being invited to one care conference meeting. b. Review of the resident's medical record showed the last 2 documented care conferences were held on 8/20/24 and 5/14/25. c. Review of the resident's care plan showed it was last revised on 7/24/25. 4. Interview with the interim DON on 8/26/25 at 5:42 PM revealed care conferences were held on a quarterly basis. Further interview revealed there was no evidence the residents participated in the planning process. 5. Review of the "Care Planning-Resident Participation" policy and procedure showed "...The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan..."	F0553	Continued from page 2 Plan to Monitor Performance: The DON or designee will audit 10% of resident records weekly for 4 weeks, then monthly for 2 months to ensure: - Care conferences are being held quarterly - Residents are invited to participate - Resident preferences are incorporated into care plans - Resident signatures are obtained after significant changes - Next conference dates are scheduled The Social Services Director or designee will report audit findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will review the audit results and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained for 3 consecutive months. Date of Compliance: 10/5/2025	
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F0578	F0578 – Request/Refuse/Discontinue Treatment; Formulate	10/03/2025

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F0578 SS = D	Continued from page 3 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 the advanced directive was formulated and accurate for 2 of 28 sample residents (#84, #93) reviewed. The findings were:	F0578	Continued from page 3 Adv Directives This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: Resident #84's advance directive was formulated and accurately documented in the electronic medical record (EMR) on 09/17/25. Resident #93 has since deceased outside the facility. Identifying other Residents having the Potential to be Affected: The Director of Nursing (DON) or designee completed an audit on 09/17/25 of current residents to identify the presence of supporting documentation for each resident's code status preference. Licensed nurses will obtain code status designation forms for those residents identified without proper documentation by 09/24/25. Measures put into place or Systemic Changes: The DON or designee will in-service licensed nurses on the facility's advance directive policy and procedure, including the requirement to obtain and accurately document code status in the EMR by 09/26/25. The "CPR Designation Form" has been added to the admission packet that is completed by the licensed nurse accepting new admissions. The Social Services Director or designee will review advance directives with residents and/or resident representatives during the admission process and document in the medical record. The Unit Manager or designee will verify accurate code status documentation in the EMR during admission and	

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F0578 SS = D	Continued from page 4 1. Review of the electronic medical record (EMR) showed resident #84 was listed as do not resuscitate (DNR). Further review of the medical record showed no evidence the resident had signed and dated an advance directive. Interview with the interim DON and MDS coordinator on 8/26/25 at 5:37 PM confirmed there was no evidence the resident had elected a DNR status. 2. Review of the EMR showed resident #93 was listed as a full code status. Review of a cardiopulmonary resuscitation (CPR) designation form provided by the interim DON on 8/26/25 at 4:48 PM was initialed "No, do not administer CPR" and signed and dated by the resident on 5/29/21. Interview with the interim DON on 8/26/25 at 4:48 PM confirmed the EHR did not match the most recent election of no CPR. 3. Review of the "Advance Directive" policy showed "... 7. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives...10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive..."	F0578	Continued from page 4 quarterly care plan reviews. Plan to Monitor Performance: Medical Records or Designee will conduct weekly audits of 10% of resident medical records to ensure advance directives are present and accurately documented in the EMR for 4 weeks, then monthly for 2 months. The DON or Designee will audit new admissions weekly for 4 weeks, then monthly for 2 months to ensure advance directives are obtained and accurately documented. The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: 10/03/25	
F0582 SS = B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F0582	F0582 Medicaid/Medicare Coverage/liability Notice This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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	10/10/2025

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F0582 SS = B	Continued from page 5 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. 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 the appropriate Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) were issued correctly for 2 of 3 sample residents (#13, #32). The findings were: 1. Review of the NOMNC/ABN for resident #13 indicated the last covered day for Medicare Part A services was 2/7/25. The following concerns were identified: a. Review of the NOMNC form showed a written note of	F0582	Continued from page 5 companies. Corrective Action for Affected Residents: On 09/26/25, the Director of Nursing (DON) or designee reviewed and corrected the Notice of Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) forms for residents #13 and #32. The forms were revised to include accurate resident information, specific reasons why Medicare may not pay for services, and estimated costs. New forms were provided to the residents or their representatives with proper signatures obtained. Identifying other Residents having the Potential to be Affected: The DON or designee will conduct a review of Medicare beneficiaries who received NOMNC and SNF ABN forms in the past 30 days by 10/01/25 to identify any similar documentation errors. Identified discrepancies were corrected and proper notices were provided to affected residents or their representatives. Measures put into place or Systemic Changes: The MDS Resource will provide in-service education on 09/29/25 to licensed nurses, social services staff, and administrative staff regarding proper completion of NOMNC and SNF ABN forms, including: - Correct resident identification - Required timeframes for notices - Proper documentation of reasons for non-coverage - Inclusion of estimated costs - Proper signature requirements - Verification process before distribution The facility has implemented a NOMNC/SNF ABN verification checklist as part of the PDPM review board process. The Social Services or Designee will review forms for accuracy before distribution. Plan to Monitor Performance: The BOM or designee will audit 10% of NOMNC and SNF ABN forms weekly for 4 weeks, then monthly for 2 months to ensure compliance with proper completion and distribution requirements. Results of these audits will be reported to the Quality	

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F0582 SS = B	Continued from page 6 "Verbal received by [resident #13's representative]" and the form was signed by the social services director on 2/4/25. b. Review of the SNF ABN form provided by the facility for resident #13 showed resident #32's name was at the top of the form. The form showed Medicare may not pay for physical therapy/occupational therapy following discharge from Medicare Part A services; however, the reason Medicare may not pay or the estimated cost was not included on the form. The form showed a written note of "Verbal received by [resident #13's representative]" and the form was signed by the social services director on 2/4/25. 2. Review of the SNF ABN form for resident #32 indicated the last covered day for Medicare Part A services was 4/14/25. The form showed Medicare may not pay for "Skilled nursing and skilled therapy"; however, the reason Medicare may not pay or the estimated cost was not included on the form. 3. Interview with the interim DON and MDS coordinator on 8/26/25 at 5:37 PM confirmed the NOMNC and ABN forms were inaccurate. 4. Review of the "Medicare Advanced Beneficiary Notice" policy showed "Residents are informed in advance when changes will occur to their bills...1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled services(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice...to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered "not medically reasonable and necessary", or "custodial." b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility. 2. If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage...to the resident at least two calendar days before Medicare covered services end (for coverage reasons). a. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination..."	F0582	Continued from page 6 Assurance and Performance Improvement (QAPI) committee monthly for review and recommendations. The QAPI committee will analyze audit findings and make additional recommendations as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/03/25 F605 Right to be free from chemical Restraints This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: The Director of Nursing (DON) or designee reviewed Resident #9's medical record on 09/04/25 and obtained a physician's order to discontinue the PRN lorazepam order. The DON or designee added Resident #9 for review during psychotropic meeting scheduled 09/23/25 to reviewed and signed by the physician. For Resident #20, the DON or designee added to psychotropic meeting review on 09/23/25 to be reviewed and signed by the physician. Identifying other Residents having the Potential to be Affected: The DON or designee conducted an audit of residents receiving psychotropic medications on 09/20/25 to identify those requiring risk-benefit assessments, GDR documentation, and PRN psychotropic medication orders requiring stop dates or physician evaluation. Residents identified through this audit	

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F0582 SS = B		F0582	Continued from page 7 have been added to the 09/23/25 scheduled Psychotropic Meeting. Measures put into place or Systemic Changes: The Clinical Rresource or designee will in-service licensed nurses on psychotropic medication requirements including PRN stop dates, GDR documentation, and risk-benefit assessments by 10/03/25. The facility has implemented a "Psychpharm Committee Review" in the electronic health record that triggers quarterly reviews for each resident receiving psychotropic medications. The Director of Nursing or designee will review new psychotropic medication orders daily during clinical morning meeting to ensure compliance with documentation requirements. Plan to Monitor Performance: The DON or designee will audit 10% of residents receiving psychotropic medications weekly for 4 weeks, then monthly for 2 months to ensure compliance with: - PRN psychotropic medication orders having appropriate stop dates - Documentation of risk-benefit assessments - GDR attempts or clinical contraindication documentation - Physician review and signatures on required documentation The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of the monitoring plan and make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/10/25	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605	F605 Right to be free from chemical Restraints This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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	10/10/2025

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F0605 SS = D	Continued from page 8 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's	F0605	Continued from page 8 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 or civil procedure and should be 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. Corrective Action for Affected Residents: The Director of Nursing (DON) or designee reviewed Resident #9's medical record on 09/04/25 and obtained a physician's order to discontinue the PRN lorazepam order. The DON or designee added Resident #9 for review during psychotropic meeting scheduled 09/23/25 to reviewed and signed by the physician. For Resident #20, the DON or designee added to psychotropic meeting review on 09/23/25 to be reviewed and signed by the physician. Identifying other Residents having the Potential to be Affected: The DON or designee conducted an audit of residents receiving psychotropic medications on 09/20/25 to identify those requiring risk-benefit assessments, GDR documentation, and PRN psychotropic medication orders requiring stop dates or physician evaluation. Residents identified through this audit have been added to the 09/23/25 scheduled Psychotropic Meeting. Measures put into place or Systemic Changes: The Clinical Rresource or designee will in-service licensed nurses on psychotropic medication requirements including PRN stop dates, GDR documentation, and risk-benefit assessments by 10/03/25. The facility has implemented a "Psychpharm Committee Review" in the electronic health record that triggers quarterly reviews for each resident receiving psychotropic medications. The Director of Nursing or designee will review new psychotropic medication orders daily during clinical morning meeting to ensure compliance with documentation requirements. Plan to Monitor Performance: The DON or designee will audit 10% of residents receiving psychotropic	

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F0605 SS = D	Continued from page 9 drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the	F0605	Continued from page 9 medications weekly for 4 weeks, then monthly for 2 months to ensure compliance with: - PRN psychotropic medication orders having appropriate stop dates - Documentation of risk-benefit assessments - GDR attempts or clinical contraindication documentation - Physician review and signatures on required documentation The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of the monitoring plan and make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/10/25	

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F0605 SS = D	Continued from page 10 attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 2 of 5 residents (#9, #20) reviewed for unnecessary medications. The findings were: 1. Review of the 3/10/25 quarterly MDS assessment showed resident #9 was admitted to the facility on 7/20/22 and had a diagnosis of schizophrenia. The resident was coded as receiving antipsychotic, antianxiety, and antidepressant medications during the 7-day look-back period. The last attempted gradual dose reduction (GDR) was documented as occurring on 12/31/24. The following concerns were identified: a. Review of the 8/24/25 "Psychotropic Medication Utilization Report" showed the resident was prescribed quetiapine fumarate (antipsychotic) and buspirone hydrochloride (an antianxiety medication), for paranoid schizophrenia with the last risk-benefit statement completed on 9/17/24; however, the facility was unable to locate the risk-benefit statement signed by the resident's physician or documentation to support the 12/31/24 GDR as noted on the 3/10/25 quarterly MDS assessment. b. Review of the physician orders showed the resident was prescribed 1 milligram (mg) of lorazepam (an antianxiety medication) every 8 hours as needed (PRN) on 8/1/25 for comfort focused care; however, no stop date was indicated. Review of the August 2025 medication administration record showed the resident had not been administered a PRN dose of lorazepam during the month. c. Interview with the interim DON on 8/27/25 at 12:56 PM confirmed the physician order for PRN lorazepam did not have a stop date. In addition, the interim DON revealed she was currently working on organizing the psychotropic medication review process. An additional interview with the interim DON at 3:15 PM confirmed the GDR documentation for resident #9 could not be located. 2. Review of the 6/26/25 quarterly MDS assessment showed resident #98 was admitted to the facility on 1/23/24 and had a diagnosis of depression. The resident was coded as receiving antipsychotics and	F0605		

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F0605 SS = D	Continued from page 11 antidepressants during the 7-day look-back period. The MDS showed no GDR was attempted or documented as being clinically contraindicated. The following concerns were identified: a. Review of the physician orders showed that the resident was prescribed 100 mg of Sertraline daily for depression on 1/23/24. b. Review of the 10/28/24 "Medication Regimen Review", signed by the physician, showed that no reduction of Sertraline was ordered at that time, and no clinical rationale was documented. c. Interview with the interim DON on 8/27/25 at 11:30 AM confirmed that no GDR was attempted and no rationale was documented for the resident.	F0605		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §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 institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	F628 Discharge Process This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: The Director of Nursing (DON) or designee reviewed the medical records of residents #6, #89, and #94 on 09/22/25. Written transfer notices and bed-hold policy information were provided to these residents and/or their representatives. The facility sent copies of these transfer notices to the Office of the State Long-Term Care Ombudsman. Identifying other Residents having the Potential to be Affected: The DON or designee conducted a review of residents transferred to the hospital in the past 30	10/03/2025

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F0628 SS = E	Continued from page 12 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F0628	Continued from page 12 days to ensure proper transfer notices and bed-hold policy information were provided to residents/representatives and the Office of the State Long-Term Care Ombudsman. Any identified deficiencies were corrected. Measures put into place or Systemic Changes: The DON or designee in-serviced Licensed Nurses on 09/22/25 regarding the facility's transfer/discharge and bed-hold policy process, including: providing written transfer notices to residents/representatives, documenting receipt of notices, providing bed-hold policy information, and notifying the Office of the State Long-Term Care Ombudsman. The Social Services Director or designee will maintain a transfer/discharge log and send monthly reports to the Office of the State Long-Term Care Ombudsman. A transfer/discharge checklist has been implemented to ensure compliance with notification requirements. Plan to Monitor Performance: The DON or designee will audit transfer records weekly for 4 weeks, then monthly for 2 months to ensure compliance with transfer notice requirements, bed-hold policy notifications, and Ombudsman notification. The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the audit findings and make recommendations for continued monitoring based on compliance. Date of Compliance: 10/03/25	

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F0628 SS = E	Continued from page 13 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the	F0628		

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F0628 SS = E	Continued from page 14 State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §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: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		

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F0628 SS = E	Continued from page 15 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a notice of transfer prior to a facility-initiated hospital transfer and provide written information on the bed-hold policy to the resident or the resident's representative for 3 of 5 sample residents (#6, #89, #94) reviewed for facility-initiated transfers. In addition, the facility failed to send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. The findings were: 1. Review of the medical record showed resident #6 was transferred to the hospital on 7/16/25. Further review showed no evidence the facility had issued a written transfer notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. 2. Review of the medical record showed resident #89 was transferred to the hospital on 7/18/25. Further review showed the Notice of Transfer/Discharge was not signed by the facility representative, and there was no verification of receipt of notice by the resident or responsible party. 3. Review of the medical record showed resident #94 was transferred to the hospital on 8/4/25. Further review showed no evidence the facility had issued a written transfer notice and written information on the bed-hold policy to the resident and/or the resident representative. There was no evidence a representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer. In addition, the resident was transferred to the hospital on 8/24/25. The facility provided a written transfer notice to the surveyor; however, it was not signed by the administrator/administrative officer or the resident/resident's representative.	F0628		

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F0628 SS = E	Continued from page 16 4. Interview with the NHA on 8/27/25 at 3:29 PM confirmed there was no record the notices were provided to the resident or resident representative or sent to the Ombudsmen. 5. Interview with the NHA on 8/27/25 at 3:29 PM confirmed no further documentation was available and was unable to locate documentation the Ombudsman had been notified of the transfers. 6. Review of the Bed Hold Notice policy showed "It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave...1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies... 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record..." 7. Review of the Transfer and Discharge (including AMA) policy showed "...10. Emergency Transfer to Acute Care...g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices..."	F0628		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a	F0637	F637 Comprehensive Assessment after significant Change This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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	10/15/2025

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F0637 SS = D	Continued from page 17 "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and review of the MDS RAI manual, the facility failed to ensure a significant change MDS assessment was completed for 1 of 28 sample residents (#10). The findings were: 1. Review of the quarterly MDS assessment dated 8/21/25 showed resident #10 had a BIMS score of 0 out of 15 which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain injury, alcoholic cirrhosis of the liver, non-Alzheimer's dementia, and depression. Further review showed the resident was coded as being on hospice care. The following concerns were identified: a. Review of the resident's medical record showed a Discharge Summary from hospice with a discharge effective date of 5/9/25 due to lack of decline. b. Interview with the interim DON on 8/26/25 at 5:53 PM confirmed the resident was discharged from hospice on 5/2/25 and revealed the facility was not notified of the discharge by hospice until 7/7/25. c. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User Manual version 1.19.11 last revised October 2024 showed "...An SCSA (Significant Change in Status Assessment) is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [Assessment Reference Date] must be within 14 days from one of the following: 10 the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 20 the expiration date of the certification of terminal illness; or 30 the date of the physician's or medical director's order stating the resident is no longer terminally ill..."	F0637	Continued from page 17 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 or civil procedure and should be 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. Corrective Action for Affected Residents: The MDS Coordinator corrected Resident #10 quarterly assessment on 09/20/25 and scheduled a Significant Change with an Assessment Reference Date (ARD) of 09/26/25, to address the resident's discharge from hospice services. Identifying other Residents having the Potential to be Affected: The Director of Nursing (DON) or designee conducted a review of residents receiving hospice services or who were discharged from hospice services in the past 90 days to identify if required Significant Change in Status Assessments were completed timely. This review will be completed by 09/25/25. Measures put into place or Systemic Changes: The MDS Resource will in-service MDS staff on the requirement to complete a Significant Change in Status Assessment within 14 days when residents discontinue hospice services. This in-service will be completed by 09/20/25. The facility has implemented a new process where the Social Services Director or designee will notify the MDS Coordinator via email when residents are discharged from hospice services. The MDS Coordinator will track these notifications on a newly developed "Hospice Status Change Tracking Log" to ensure timely completion of required assessments. Plan to Monitor Performance: The MDS Coordinator or designee will audit hospice service records weekly for 4 weeks, then monthly for 2 months to ensure Significant Change in Status Assessments are completed within 14 days of hospice service discontinuation.	

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F0637 SS = D		F0637	Continued from page 18 The DON or designee will review the "Hospice Status Change Tracking Log" weekly for 4 weeks, then monthly for 2 months to ensure proper notification and timely completion of required assessments. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee monthly for review and recommendations. The QAPI committee will determine the need for ongoing monitoring based on audit results. Date of Compliance: 10/15/25	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for	F0641	F641 Accuracy of Assessments This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: The Director of Nursing (DON) or designee ensured the following corrective actions were completed: For Resident #12, on 09/20/25, the Minimum Data Set (MDS) Coordinator completed a modification to the 7/1/25 annual MDS assessment to accurately reflect the resident's PASRR Level II status in section A1500. For Resident #55, on 09/20/25, the MDS Coordinator completed a modification to the 4/18/25 annual MDS assessment to include the required section GG functional assessment data. Identifying other Residents having the Potential to be	10/03/2025

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F0641 SS = D	Continued from page 19 each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and review of the MDS RAI manual, the facility failed to ensure MDS assessments were accurate for 3 of 28 sample residents (#10, #12, #55). The findings were: 1. Review of the 2/9/22 Wyoming PASRR (pre-admission screening and resident review) Level II Determination Summary Report showed resident #12 had psychiatric diagnoses which included bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, and sleep terror. Further review showed the resident met the state definition of mental illness. The following concerns were identified: a. Review of the 7/1/25 annual MDS assessment showed section A1500 was marked no to the question if the resident was currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability. b. Interview on 8/26/25 at 2:38 PM with the MDS coordinator confirmed section A1500 was marked inaccurately. 2. Review of the 4/18/25 annual MDS assessment for resident #55 showed section GG (used to assess functional abilities and goals) was marked as not assessed. Interview on 8/26/25 at 2:38 PM with the MDS coordinator revealed the facility did not have staff available at that time to perform the assessment so section GG was "dashed out". 3. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual version 1.19.11 last revised October 2024 showed "...A1500: Preadmission Screening and Resident Review (PASRR)...code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1520, Level II Preadmission Screening and Resident Review (PASRR) Conditions." Section GG of the RAI manual showed the intent of this section included items focused on prior function, admission and discharge performance, discharge goals, performance throughout a resident's stay, mobility device use, and range of	F0641	Continued from page 19 Affected: The MDS Coordinator or designee conducted an audit of current residents with PASRR Level II determinations to ensure section A1500 is coded accurately on their most recent MDS assessments. Additionally, the MDS Coordinator reviewed MDS assessments completed in the past 3 months to ensure section GG was properly completed for each assessment. This audit will be completed by 10/01/25. Measures put into place or Systemic Changes: The DON or designee will in-service MDS staff on proper MDS coding procedures, with emphasis on PASRR Level II documentation in section A1500 and completion requirements for section GG functional assessments. This in-service will be completed by 10/03/25. Plan to Monitor Performance: The MDS Coordinator or designee will audit 10% of completed MDS assessments weekly for 4 weeks, then monthly for 2 months to ensure accurate coding of section A1500 for residents with PASRR Level II determinations and proper completion of section GG assessments. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will review the results and make recommendations for additional corrective actions if needed until substantial compliance is achieved and maintained. Date of Compliance: 10/03/25	

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F0641 SS = D	Continued from page 20 motion. Functional status was assessed based on the resident's need for assistance when performing self-care and mobility activities.	F0641		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative and staff interview, and medical record review, the facility failed to provide services to prevent, treat, and heal pressure ulcers for 1 of 4 sampled residents (#98) reviewed for pressure ulcers. This failure resulted in actual harm to resident #98 who developed pressure ulcers. The findings were: 1. Review of the admission MDS assessment, dated 5/18/25, showed resident (#98) had a BIMS score of 3 out of 15, which indicated s/he had severe cognitive impairment, and diagnoses which include type 2 diabetes mellitus, chronic kidney disease, coronary artery disease, and heart failure. Further review showed no wounds were present upon admission and the resident was at risk for pressure ulcers / injuries. The following concerns were identified: a. Review of a physician note, dated 5/15/25, showed the resident had a nickel sized unstageable pressure ulcer located on his/her right buttocks with orders for wound care and monitoring. Review of the medical record showed no treatment orders for wound care or monitoring. b. Review of the skilled nursing evaluation, dated	F0686	F686 Treatment/Svc to prevent/Heal Pressure Ulcers This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: Resident #98 discharged from the facility on 5/26/25. The Director of Nursing (DON) or designee conducted a comprehensive review of Resident #98's medical record to identify gaps in pressure ulcer prevention and treatment documentation. Identifying other Residents having the Potential to be Affected: The DON or designee completed an audit of current residents to identify those with pressure ulcers/injuries and validate that appropriate treatments and preventive measures are in place. The DON or designee reviewed skin assessments, physician orders, and treatment administration records to ensure proper documentation and implementation of wound care. Measures put into place or Systemic Changes: The DON or designee will in-service licensed nurses on: - Proper documentation of skin alterations including location, size, stage, and characteristics - Timely notification of the physician and obtaining	10/03/2025

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F0686 SS = G	Continued from page 21 5/21/25 and timed 1:30 PM, showed the resident had an abraded area noted to the buttocks and cream was applied by RN #1. c. Review of the skilled nursing evaluation, dated 5/22/25 and timed 11:25 PM showed new pressure ulcers were present to the right and left heels, left medial calf, and an abrasion to the coccyx. Further review showed RN #1 notified the DON of the new ulcers, the DON observed pressure areas, and the DON planned to discuss the new ulcers with the certified wound nurse regarding treatment options. d. Review of a physician note dated 5/25/25 showed the resident had prevalon boots and orders to continue with wound care until completely healed. Review of the resident's medical record showed no evidence the prevalon boots, or wound care was added to the orders until 5/27/25. e. Interview with the resident's representative on 8/27/25 at 5:12 PM revealed the resident had been sent to the emergency room for another matter on 5/26/25 and the physician found concerning pressure ulcers on the resident's heels and buttocks. The resident did not return to the facility following the emergency room visit. f. Interview with the interim DON on 8/27/25 at 5:30 PM confirmed there were no wound care orders or documentation the facility was treating the resident's pressure ulcers prior to 5/27/25, after the resident had discharged.	F0686	Continued from page 21 treatment orders - Implementation of pressure-relieving devices and preventive measures - Documentation requirements for wound care treatments and monitoring The facility has revised its skin assessment and wound care protocol to include: - Weekly skin assessments by licensed nurses - Documentation requirements for new skin alterations - Process for obtaining and implementing physician orders - Communication requirements between shifts regarding skin alterations - Implementation of pressure-relieving devices Plan to Monitor Performance: The DON or designee will conduct weekly audits of 10% of residents with pressure ulcers/injuries for 4 weeks, then monthly for 3 months to ensure: - Skin alterations are properly documented - Physician orders are obtained and implemented timely - Treatment administration records are complete - Pressure-relieving devices are in place as ordered - Weekly skin assessments are completed The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the data and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained. Date of Compliance: 10/03/25	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	F689 Free of accidents hazards supervision/Devices	10/10/2025

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F0689 SS = D	Continued from page 22 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interview, the facility failed to ensure an environment was free from accident hazards for 2 of 3 residents (#7, #9) reviewed for smoking. The findings were: 1. Review of the quarterly MDS assessment, dated 7/29/25, showed resident #7 had a BIMS score of 14 out of 15 (cognitively intact). The following concerns were identified: a. Observation on 8/25/25 at 3:59 PM showed the resident smoked in the courtyard during the scheduled smoking time. b. Review of the resident's medical record showed the last safe smoking evaluation was dated 3/10/25. Review of the resident's care plan, last updated 6/12/25, did not address smoking. 2. Review of the 12/8/24 annual MDS assessment for resident #9 showed s/he was admitted to the facility on 7/20/22, had a BIMS score of 13 out of 15 (cognitively intact), and had diagnoses which included schizophrenia, respiratory failure, and COPD (chronic obstructive pulmonary disease). Review of the resident's care plan, dated 3/31/23, showed the resident was a "smoker/uses tobacco products" and was to be reevaluated "via safe smoking evaluation quarterly and as needed." Review of the "Resident Smoking" policy showed "...6. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. 7. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any	F0689	Continued from page 22 This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: Resident #7 and Resident #9 had safe smoking evaluations completed on 09/21/25. The Director of Nursing (DON) or designee updated Resident #7's care plan to include smoking interventions on 09/21/25. The DON or designee reviewed Resident #9's care plan to ensure smoking interventions remained current and appropriate on 09/21/25. Identifying other Residents having the Potential to be Affected: The DON or designee conducted an audit on 09/21/25 to identify residents who smoke. These residents were assessed for safe smoking practices, and their care plans were reviewed to ensure smoking interventions were addressed appropriately. Measures put into place or Systemic Changes: The DON or designee will in-service licensed nurses on the facility's smoking policy, including requirements for quarterly smoking evaluations and care plan updates by 10/10/25. The Unit Manager or designee will maintain a smoking assessment tracking log to ensure timely completion of quarterly smoking evaluations. The MDS Coordinator or designee will review smoking care plans during the quarterly MDS assessment process to ensure interventions are current and appropriate. Plan to Monitor Performance: The DON or designee will audit smoking assessments and care plans for residents who smoke weekly for 4 weeks, then monthly for 2 months	

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F0689 SS = D	Continued from page 23 additional safety measures are indicated..."The following concerns were identified: a. Review of the resident's medical record showed the last documented "Smoking and Safety" evaluation was completed on 1/28/25. 3. Interview with the interim DON and MDS coordinator on 8/26/25 at 5:43 PM confirmed there was no additional documentation available and smoking should be addressed in the care plan and assessed quarterly. 4. Review of the policy and procedure titled "Resident Smoking" showed "...8. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan..."	F0689	Continued from page 23 to ensure compliance with facility policy. The Unit Manager or designee will review the smoking assessment tracking log weekly for 4 weeks, then monthly for 2 months to ensure timely completion of quarterly assessments. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the audit results and make recommendations for continued monitoring based on compliance. Date of Compliance: 10/10/25	
F0740 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 record review, staff interview, and policy and procedure review, the facility failed to ensure residents with mental disorders received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 3 sample residents (#30) reviewed for behavioral and emotional needs. The findings were: 1. Review of the comprehensive MDS assessment dated 7/28/25 showed resident #30 had a BIMS score of 15 out of 15 which indicated intact cognition, and diagnoses which included bipolar disorder, other specified depressive episodes, other mixed anxiety disorders, cognitive communication deficit, and drug induced subacute dyskinesia. Review of the 5/18/25 quarterly	F0740	F740 Behavioral Health Services This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/27/25, Resident #30 was evaluated by a licensed psychologist. The Director of Nursing (DON) or designee scheduled a comprehensive psychiatric evaluation for Resident #30 to be completed by 10/10/2025. The Social Services Director or designee arranged behavioral health counseling services for Resident #30 to begin 10/1/2025. The care plan was updated to reflect these interventions on 8/27/25.	10/16/2025

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F0740 SS = D	Continued from page 24 MDS assessment showed the resident exhibited physical behavioral symptoms directed toward others 1 to 3 days of the 7-day look-back period, verbal behavioral symptoms directed at others 1 to 3 days of the 7-day look-back period, and rejection of evaluation or care 1 to 3 days of the 7-day look-back period. The following concerns were identified: a. Review of the resident's medical record showed a Wyoming PASRR (Preadmission Screening and Resident Review) Level II determination was completed on 3/15/21. Psychiatric diagnoses on the PASRR Level II included other mixed anxiety disorders, other specified depressive disorders, paranoid schizophrenia and bipolar disorder. Recommendations from the PASRR included supportive counseling from nursing facility staff and a minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan. Behaviors on the care plan showed the resident cursed and yelled at others, called his/her physician and other organizations up to 8 times per day, and had a history of false accusations. b. Review of the resident's entire medical record showed no evidence a psychological evaluation had been completed. c. Review of the resident's care plan showed "intervention recommendations through PASRR II is the following: Family involvement in the clients care if available, Psychotropic medication monitoring, Educations regarding medication compliance and/or side effects, supportive counseling from NF [nursing facility] staff, Psychiatric records to clarify history and Minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan. Date initiated: 03/15/2021." Further review showed resident behaviors included calling his/her physician and other organizations up to 8 times per day, agitation and restlessness, refusal of cares, and yelling and cursing at others. d. Interview with the ombudsman on 8/25/25 at 3:55 PM revealed the resident frequently called, sometimes several times a day, and yelled and cussed at her. She reported she had asked the social services director to look into counseling for the resident but she did not hear back from him regarding that request. e. Interview with the interim DON on 8/27/25 at 9:54 AM revealed the resident did not receive counseling services, and the resident's physician "talks with	F0740	Continued from page 24 Identifying other Residents having the Potential to be Affected: The Social Services Director or designee conducted a review of residents with PASRR Level II recommendations on 8/28/25 to identify residents requiring psychological/psychiatric evaluations or counseling services. Residents identified through this review will receive necessary evaluations and services by 10/1/2025. Measures put into place or Systemic Changes: The DON or designee developed and implemented a PASRR Level II tracking system on 8/29/25 to ensure recommended services are provided. The Social Services Director or designee will in-service licensed nurses and social services staff on PASRR Level II requirements, including implementation of recommended behavioral health services by 10/1/2025. The facility has established contracts with behavioral health providers to ensure access to psychological/psychiatric evaluations and counseling services. The DON or designee revised the behavioral health assessment policy to include monitoring of PASRR Level II recommendations on 8/29/25. Plan to Monitor Performance: The Social Services Director or designee will audit resident records with PASRR Level II recommendations weekly for 4 weeks, then monthly for 2 months to ensure recommended services are provided. The DON or designee will review new admissions weekly to identify residents with PASRR Level II recommendations and ensure services are arranged. The Social Services Director or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will review the data and make recommendations for continued monitoring until substantial compliance is achieved. Date of Compliance: 10/16/2025	

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F0740 SS = D	Continued from page 25 [him/her] weekly but does not document it." Further interview confirmed the resident had not received a yearly psychiatric evaluation.	F0740		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by:	F0756	F756 Drug Regimen Review report irregularity, acted on This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/27/25, the Director of Nursing (DON) or designee reviewed Resident #9's medical record to ensure the pharmacist's monthly medication regimen review was completed for March, April, May, and June 2025. The DON or designee contacted the consulting pharmacist to complete medication regimen reviews for the missing months. The pharmacist completed these reviews on 8/28/25, and any identified irregularities were reported to the attending physician, medical director, and DON for appropriate action and documentation. Identifying other Residents having the Potential to be Affected: The DON or designee conducted an audit of resident medical records to identify residents receiving medications who require monthly pharmacist medication regimen reviews. The DON or designee reviewed the pharmacist's monthly medication review binder to ensure documentation of completed reviews for the past 90 days. Measures put into place or Systemic Changes: The DON or designee developed and implemented a new policy and procedure for tracking monthly pharmacist medication	10/17/2025

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F0756 SS = D	Continued from page 26 Based on medical record review, staff interview, and review of the interim DON's pharmacist monthly medication review binder, the facility failed to have a system in place to ensure the pharmacist's monthly medication reviews and recommendations were acted upon and documented in the resident's record for 1 of 5 sample residents (#9) reviewed for unnecessary medications. The findings were: Review of the 3/10/25 quarterly MDS assessment showed resident #9 was admitted to the facility on 7/20/22 and had a diagnosis of schizophrenia. The resident was coded as receiving antipsychotic, antianxiety, and antidepressant medications during the 7-day look-back period. Review of the resident's medical record and the interim DON's pharmacist monthly medication review binder showed no evidence the pharmacist had performed a monthly medication review which included any irregularities or recommendations for March, April, May, or June of 2025. Interview with the interim DON on 8/27/25 at 12:56 PM revealed she was in the process obtaining the missing documentation and updating the binder.	F0756	Continued from page 26 regimen reviews on 10/3/2025. The Licensed Pharmacist will complete medication regimen reviews monthly and document findings in a separate written report. The DON or designee will maintain a tracking log to ensure timely completion of reviews. The DON or designee will in-service Licensed nurses, Unit Managers, and consulting pharmacist on the new policy and procedure for monthly medication regimen reviews, including: - Requirements for monthly completion - Documentation requirements - Process for addressing identified irregularities - Timeline for physician review and response - Storage and maintenance of review documentation Plan to Monitor Performance: The DON or designee will audit 10% of resident medical records monthly for 3 months to ensure: - Monthly pharmacist medication regimen reviews are completed - Irregularities are properly documented and reported - Physician review and response to irregularities are documented - Required documentation is maintained in the medication review binder The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/16/2025	
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761	F761 Label/Store Drugs and Biologicals This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute admission on the part of the Community as to the accuracy of the surveyors'	10/10/2025

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F0761 SS = D	Continued from page 27 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 §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, and manufacture instructions, the facility failed to label medications with the date opened in 1 of 4 medication storage areas (400 hall medication cart). The findings were: 1. Observation of the 400 hall medication cart on 8/26/25 at 12:07 PM showed a Lantus vial which was opened and undated. Review of the manufacturer's instructions titled "Patient Medication Information - Lantus Vial" last revised 12/1/21 showed opened insulin vials must be discarded after 28 days of opening. 2. Interview with RMA #1 on 8/26/25 at 12:07 PM revealed staff were responsible for labeling multidose vials of medications to indicate the date the medication was opened.	F0761	Continued from page 27 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/26/25, the Resident Medication Assistant (RMA) removed the undated Lantus vial from the 400 hall medication cart and replaced it with a new supply that was properly labeled with the date opened. Identifying other Residents having the Potential to be Affected: On 8/26/25, the Director of Nursing (DON) or designee conducted an audit of medication storage areas, including medication carts and medication rooms, to identify any other multi-dose vials or medications requiring dating when opened. No other undated items were identified. Measures put into place or Systemic Changes: The Staff Development Coordinator (SDC) or designee provided in-service education to Licensed Nurses and Medication Aides Certified (MACs) on 9/30/2025: - Requirements for labeling medications upon opening - Proper storage of medications including temperature controls - Manufacturer's guidelines for storage and dating of multi-dose vials - Facility policy and procedure for medication storage and labeling The DON or designee updated the medication storage and labeling policy to include a requirement for checking medication expiration dates and proper labeling during each medication pass. Plan to Monitor Performance: The Unit Manager or designee will conduct weekly audits of medication	

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F0761 SS = D		F0761	Continued from page 28 storage areas for proper labeling and dating of medications for 4 weeks, then monthly for 2 months. The audit results will be documented on a medication storage audit tool. Any identified issues will be corrected immediately, and additional education provided as needed. The DON or designee will report audit findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly for review and recommendations until substantial compliance is achieved and maintained for 3 consecutive months. Date of Compliance: 10/10/2025	
F0802 SS = E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to employ a sufficient number of staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services. The census was 82. The findings were: 1. Observation on 8/26/25 starting at 11:30 AM showed dietary aide #1 and cook #1 began the noon meal service by first preparing plates for the residents which required assistance with eating and were served in the	F0802	F802 Sufficient Dietary Support This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/26/25, the Dietary Manager or designee ensured adequate dinnerware was available for all meal services by implementing an immediate inventory count system and ordering additional dinnerware sets. The facility discontinued the use of disposable plates for regular meal service. Identifying other Residents having the Potential to be Affected: The Dietary Manager or designee conducted a comprehensive review of dinnerware inventory and dishwashing processes on 8/26/25 to ensure adequate	10/16/2025

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F0802 SS = E	Continued from page 29 Sunflower dining room. The meals were served on dinnerware with the exception of residents who required special utensils and plates. At 11:40 AM dietary aide #1 and cook #1 prepared room trays using dinnerware to serve the meal. Service to the main dining room began at 11:45 AM and approximately three quarters of the way through service the dinnerware was switched to black foam disposable plates. 2. Interview with cook #1 on 8/26/25 at 12:01 PM revealed the facility did not have enough clean dinnerware for all of the residents and had to switch to disposable plates. Cook #1 stated this "happened more often than it should." 3. Interview with the dietary manager on 8/26/25 at 12:15 PM revealed if the facility had 2 dietary aides during the day, the aides were responsible for retrieving the room trays and washing the dishes before the next meal service; however, if the kitchen was short a dietary aide it was up to the CNAs to return the room trays to the kitchen. The dietary manager stated when the CNAs were responsible the room trays would "trickle" in and this did not always leave enough time to wash the dishes.	F0802	Continued from page 29 supplies for resident meals. This issue had the potential to affect residents receiving meals in their rooms and in dining areas. Measures put into place or Systemic Changes: The Dietary Manager or designee implemented the following measures: - Purchased additional dinnerware sets to ensure adequate supply for all meal services on 8/27/25 - Revised dish collection protocol requiring dietary staff to collect room trays immediately after meals - Created a schedule to ensure 2 dietary aides are available during meal services - Developed a dishware inventory tracking system - The Director of Nursing (DON) or designee will in-service dietary staff and Certified Nursing Assistants (CNAs) on proper tray collection procedures and timing by 10/1/2025 - A temporary dish sanitizing station has been set up while awaiting water heater replacement - New water heater installed on 9/18/2025 Plan to Monitor Performance: The Dietary Manager or designee will: - Conduct daily dinnerware inventory checks for 4 weeks - Audit meal service processes 3 times per week for 4 weeks, then weekly for 8 weeks to ensure adequate dinnerware availability - Monitor tray collection timing and process daily for 4 weeks	

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F0802 SS = E		F0802	Continued from page 30 - Review staffing schedules weekly to ensure adequate dietary personnel coverage The Dietary Manager or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of interventions and adjust as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/16/2025	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 1 food preparation area. The census was 82. The findings were: 1. Observation on 8/24/25 at 1:10 PM showed an upright fan was blowing on a food preparation area located in front of the 3-compartment sink. On the food preparation counter was a cutting board and knife. The	F0812	F812 Food Procurement Storage/Prepare/Serve/Sanitary This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/26/25, the soiled fan was immediately removed from the food preparation area and thoroughly cleaned. The pipes and rack storage area behind the grill/oven were deep cleaned and sanitized to ensure a safe food preparation environment. Identifying other Residents having the Potential to be Affected: The Director of Food and Nutrition Services (DFNS) or designee conducted a thorough inspection of the kitchen and food preparation areas on 8/26/25 to identify any other potential sources of contamination or unsanitary conditions that could affect food safety for residents.	10/03/2025

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F0812 SS = E	Continued from page 31 fan was darkened and soiled with debris. Further observation showed a rack used to store clean utensils and cookware was located directly behind the hooded gas cooking area. Between the grill/oven area and the storage rack were pipes that were visibly dirty and soiled. 2. Observation on 8/26/25 at 9:04 AM showed the upright fan was blowing on the same food preparation area where dietary aide #1 was preparing individual syrup cups for residents. Interview with the dietary manager and cook #1 at that time confirmed the fan was not clean. Cook #1 immediately disconnected the fan and took it apart to clean it. The area behind the grill/oven remained the same. 3. Interview with the dietary manager on 8/26/25 at 12:15 PM confirmed the area behind the grill/oven area was not clean and was not included on the cleaning schedule.	F0812	Continued from page 31 Measures put into place or Systemic Changes: The DFNS or designee has updated the kitchen cleaning schedule to include daily cleaning of equipment, fans, and pipes in food preparation areas. The cleaning schedule now specifically includes the area behind the grill/oven. The DFNS or designee will provide in-service education to Food and Nutrition Services staff by 9/24/2025 regarding proper cleaning procedures, sanitation requirements, and the updated cleaning schedule. No portable fans will be permitted in food preparation areas. The facility's infection preventionist (IP) or designee will review and approve cleaning protocols to ensure they meet infection control standards. Plan to Monitor Performance: The DFNS or designee will conduct daily inspections of the kitchen and food preparation areas for the next 30 days to ensure compliance with sanitation standards and cleaning schedules. After 30 days, inspections will occur weekly for 60 days, then monthly thereafter. Results of these inspections will be documented on a Kitchen Sanitation Audit tool. The DFNS or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for review and recommendations. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months. Date of Compliance: 10/3/2025	
F0880 SS = F	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: §483.80(a)(1) A system for preventing, identifying,	F0880	F880 Infection Control This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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	10/10/2025

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F0880 SS = F	Continued from page 32 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. §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.	F0880	Continued from page 32 companies. Corrective Action for Affected Residents: The Director of Nursing (DON) or designee ensured Resident #84's bed frame was replaced on 8/26/25 to properly secure the foley catheter bag above floor level. The 14 residents affected by the gastrointestinal outbreak were placed on appropriate precautions and monitored for symptoms. The facility implemented outbreak control measures including enhanced cleaning protocols and isolation procedures on 8/24/25. Identifying other Residents having the Potential to be Affected: The DON or designee completed an audit on 8/26/25 of residents with indwelling catheters to ensure proper bed frames were in place for secure catheter bag placement. The Infection Preventionist (IP) or designee reviewed infection surveillance data from the past 30 days to identify any additional unreported outbreaks or infection control issues. Measures put into place or Systemic Changes: The DON or designee provided in-service education to nursing staff on 8/26/25 regarding proper catheter care and infection control practices, including maintaining catheter bags off the floor. The facility's water management program was fully implemented on 8/27/25, including documentation logs for control measures and monthly data review. The IP or designee updated the infection control policy to include specific criteria and procedures for outbreak reporting to state/local health authorities. Licensed nurses were in-serviced on 9/24/2025 regarding outbreak identification and reporting requirements. Plan to Monitor Performance: The Unit Managers or designee will conduct weekly audits of catheter care practices for 4 weeks, then monthly for 2 months to ensure compliance. The Maintenance Director or designee will review water management logs weekly and report findings monthly. The IP or designee will review infection surveillance data weekly to identify potential outbreaks and verify appropriate reporting. Audit results will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for review and additional interventions as needed until substantial compliance is achieved and maintained for 3 consecutive months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , Casper, Wyoming, 82601**

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F0880 SS = F	Continued from page 33 §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, staff interview, review of the facility "Outbreak Investigation Tool," State Licensing incident database review, and policy and procedure review, the facility failed to implement a water management program to prevent, detect, and control the risk of water-borne pathogens, failed to report an outbreak of infectious disease involving 14 residents, and failed to ensure effective infection control practices were followed during 2 random observations. The census was 82. The findings were: 1. Observation on 8/24/25 at 5:08 PM showed resident #84 was in bed and his/her catheter bag was lying flat on the floor. Interview with CNA #1 at that time revealed the bed did not have a place to hang the bag so it was put on the floor. Observation on 8/25/25 at 9:25 AM showed resident #84 was in bed and his/her catheter bag was placed in a dignity bag and lying flat on the floor. Interview with the interim DON and the ADON on 8/26/25 at 3:14 PM confirmed catheter bags should not be placed directly on the floor. 2. Review of the Legionella Water Safety Program policy, dated 7/29/25 showed control measures had been identified and the facility was to "Maintain logs for each control measure, including corrective actions taken for out-of-range values. Review data monthly to detect trends or deficiencies." Interview with the NHA on 8/27/25 at 2:15 PM revealed the water management plan for Legionella had not been implemented. 3. Observation on 8/24/25 at 1 PM showed several residents had been confined to their room due to a gastrointestinal outbreak with symptoms of nausea, diarrhea, and vomiting. Review of the "Outbreak Investigation Tool" showed the outbreak began on 8/22/25 and involved 14 residents. Review of the state licensing agency incident data base showed no evidence the facility had reported an infectious disease outbreak. Interview with the interim DON on 8/27/2025 at 3:41 PM revealed she was unaware of the requirement.	F0880	Continued from page 33 Date of Compliance: 10/10/2025	
F0883 SS = D	Influenza and Pneumococcal Immunizations	F0883	F883 Influenza and Pneumococcal Immunizations	10/17/2025

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F0883 SS = D	Continued from page 34 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F0883	Continued from page 34 This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents: On 8/26/25, the Director of Nursing (DON) or designee reviewed Resident #59's medical record and provided education regarding the benefits and potential side effects of both the influenza and pneumococcal vaccines. The education was documented in the medical record, and a new consent/declination form was completed indicating the resident's choice regarding vaccination. Identifying other Residents having the Potential to be Affected: The DON or designee conducted a medical record audit of current residents to identify those lacking documentation of vaccine education and consent/declination forms. This audit was completed on 8/27/25. Residents identified with missing documentation received education on vaccine benefits and risks, and new consent/declination forms were completed. Measures put into place or Systemic Changes: The DON or designee revised the facility's immunization documentation process on 8/28/25 to include: - Implementation of a new tracking system to monitor vaccine education and consent documentation - Creation of a vaccine documentation checklist for admission nurses - Development of an immunization documentation audit	

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F0883 SS = D	Continued from page 35 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and review of facility policies, the facility failed to have a system in place to maintain documentation residents were provided education regarding the benefits and potential side effects of the pneumococcal and influenza vaccines and documentation of the consent or refusal of the immunization for 1 of 4 sample residents (#59) reviewed for immunizations. The findings were: 1. Review of the 8/8/25 annual MDS assessment showed resident #59 was admitted to the facility on 10/21/22. Further review of the MDS assessment showed the resident was offered and had declined the influenza and pneumococcal vaccines. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 2. Interview with the interim DON and ADON on 8/26/25 at 3:14 PM confirmed no further documentation was available. 3. Review of the Influenza Vaccine policy showed "1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized...4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine...Provision of such education shall be documented in the resident's/employee's medical record. 5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record. 6. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. 4. Review of the Pneumococcal Vaccine policy showed "1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series,	F0883	Continued from page 35 tool The DON or designee will provide in-service education to Licensed Nurses on mm/dd/yyyy regarding: - Proper documentation of vaccine education - Completion of consent/declination forms - Use of the new tracking system - Requirements for maintaining vaccination records Plan to Monitor Performance: The Infection Preventionist (IP) or designee will conduct weekly audits of 10% of resident medical records for 4 weeks, then monthly for 2 months to ensure proper documentation of vaccine education and consent/declination forms. The IP or designee will also audit vaccination records for new admissions weekly for 4 weeks, then monthly for 2 months. The IP or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review findings and make additional recommendations as needed until substantial compliance is achieved and maintained. Date of Compliance: 10/17/2025	

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F0883 SS = D	Continued from page 36 and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series...3. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine...Provision of such education is documented in the resident's medical record...5. Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of refusal of the pneumococcal vaccination. 6. For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record..."	F0883		
F0887 SS = E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the	F0887	F887 Covid-19 Immunization This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute 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 or civil procedure and should be 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. Corrective Action for Affected Residents - The Director of Nursing (DON) or designee reviewed the medical records of residents #9, #10, #59, and #84 on 8/26/25. The DON or designee provided education regarding the benefits, risks, and potential side effects of the COVID-19 vaccine to these residents and/or their representatives. Documentation of the education provided, and consent/declination forms were completed and filed in their medical records.	10/16/2025

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F0887 SS = E	Continued from page 37 opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and review of policy and procedures, the facility failed to have a system in place to maintain documentation residents were provided education regarding the benefits and potential side effects of the COVID-19 vaccination and documentation of the consent or refusal of the immunization for 4 of 4 sample residents (#9, #10, #59, #84) reviewed for immunizations. The findings were: 1. Review of the 7/28/25 quarterly MDS assessment for resident #9 showed s/he was admitted to the facility on 7/20/22 and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 2. Review of the 8/8/25 quarterly MDS assessment for resident #10 showed s/he was admitted to the facility	F0887	Continued from page 37 Identifying other Residents having the Potential to be Affected - The DON or designee conducted a facility-wide audit of resident medical records to identify residents who lack documentation of COVID-19 vaccine education and consent/declination forms. The audit was completed on 8/28/25. Measures put into place or Systemic Changes - The Infection Preventionist (IP) or designee revised the facility's COVID-19 vaccination policy and procedure to include a standardized process for documenting resident education and maintaining consent/declination forms on 8/29/25. The DON or designee provided in-service education to Licensed Nurses by 9/30/2025 regarding: - Proper documentation requirements for COVID-19 vaccine education - Use of consent/declination forms - Storage of documentation in resident medical records - Process for tracking resident COVID-19 vaccination status A COVID-19 vaccination tracking tool was implemented to monitor resident vaccination status, education provided, and documentation compliance. Plan to Monitor Performance - The IP or designee will conduct weekly audits of resident medical records for 4 weeks, then monthly audits for 2 months to ensure proper documentation of COVID-19 vaccine education and consent/declination forms. The Unit Manager or designee will audit new admission records within 72 hours of admission to ensure compliance with documentation requirements. The IP or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will review the data and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained. Date of Compliance: 10/16/2025	

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F0887 SS = E	Continued from page 38 on 10/31/24 and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 3. Review of the 8/8/25 annual MDS assessment for resident #59 showed s/he was admitted to the facility on 10/21/22 and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 4. Review of the 6/22/25 quarterly MDS assessment fore resident #84 showed s/he was admitted to the facility on 3/17/25 and was coded as not being up-to-date on the COVID-19 vaccination. Further review of the medical record failed to show evidence the resident was educated on the benefits and risks of the vaccines and a copy of the consent/declination form was maintained. 5. Interview with the interim DON and ADON on 8/26/25 at 3:14 PM confirmed no further documentation was available. 6. Review of the "Coronavirus Disease (COVID-19) - Vaccination of Residents" policy showed "Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. 1. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. 2. The resident (or resident representative) can accept or refuse a COVID-19 vaccine and can change his/her decision. 3. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee...6. Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine...10. Residents must sign a consent to vaccinate form prior to receiving the vaccine. The form is provided to the resident in a language and format understood by the resident or representative	F0887		