STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. Building B. Wing	05/18/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38149 Based on medical record review, and resident interview and staff interview, the facility failed to ensure residents were free from physical abuse for 1 of 5 residents (#2) reviewed for behavioral symptoms. This failure resulted in harm to resident #2, who was punched in the face by another resident, and sustained bruises to the face and wrist. The findings were: 1. Review of the 5/4/22 quarterly MDS assessment for resident #1 showed the resident was admitted on [DATE] with diagnoses which included unspecified dementia with behavioral disturbance. The resident had severe cognitive impairment with a BIMS score of 4 out of 15. The resident also had physical and verbal behavioral symptoms on 1 to 3 days during the look back period. Review of the 4/21/22 annual MDS assessment for resident #2 showed the resident had diagnoses which included dementia and anxiety. The resident had a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Review of the Medication Regimen Review for resident #1, dated 12/21/21, showed a recommendation signed by the physician that read, .continue the prn Haldol [an antipsychotic medication], still necessary to prevent harm to others . Review of the quarterly Psychotropic Medication Management Review dated 3/15/22 showed the following recommendations: .dangerous behaviors less frequent only 1 time use of prn Haldol this month. Review of the progress note dated 4/20/22 and timed 12:22 PM showed the resident was given Haldol due to agitation, yelling and accusing the laundry of stealing his/her clothes. Further review showed staff tried to redirect him/her, however s/he continued to yell at other residents about the laundry. Review of the progress note dated 4/26/22 and timed 4:04 PM showed resident #1 was upset about his/her roommate, resident #2. Resident #1 stated resident #2 turned off his/her television without permission. Further review showed the resident was yelling and showed aggression toward the staff by pushing a bedside table through the room-dividing curtain towards the staff. Review of the progress note dated 4/29/22 and timed 2:58 PM showed resident #1 was very agitated about his/her roommate and the television. Further review showed while maintenance was providing resident #1 with a different television remote, resident #1 called his/her roommate a b*tch. The note further showed when resident #1 was returning to his/her room and saw the roommate in a common area, s/he yelled at the roommate calling him/her a b*tch. Staff were able to prevent resident #1 from approaching the roommate at that time. The following concerns were identified: (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. Review of the progress note for resident #1 dated 5/3/22 and timed 1:45 PM showed the writer .heard screaming from room, CNA noted resident hitting [his/her] roommate in the face and [his/her] arm. Immediately intervened, resident swinging at the CNA also, resident assisted to stationary chair and roommate removed from room to safety .roommate and belongings removed from room, resident is on 15 minute checks. b. Review of the SBAR Summary dated 5/3/22 and timed 1:45 PM showed resident #2 was in his/her room watching television when resident #1 came in the room, hit him/her, knocked his/her glasses off, and hit his/her right arm. Further review showed resident #2 had a bruise to the face and right wrist, and interventions included ice application to right cheek, and moving resident #2 to another room. Review of the Treatment Administration Record for May 2022 showed an order to monitor the bruising to resident #2's right cheek and right wrist until resolved. c. Interview with CNA #1 on 5/17/22 at 4:20 PM revealed on 5/3/22 resident #1 was agitated and threatening to kill his/her roommate. The CNA stated resident #1 came out to the common area. The CNA thought resident #1 had calmed down and saw the resident walk to to his/her room. The CNA stated resident #2 was in the room watching television. The CNA stated she heard screaming and yelling from the room and when she got to the room resident #1 stated s/he hit the f*cking b*tch. The CNA stated she got between the residents and resident #1 hit her. She further stated the nurse came to the room and they immediately removed resident #2 from the room. d. Interview on 5/17/22 at 1:00 PM with resident #2 revealed s/he had a previous roommate (resident #1) who was upset with her over the television remote control. S/he said they were both able to change each other's channel and didn't know it. S/he stated resident #1 got angry and hit him/her, and this upset resident #2. e. Interview on 5/17/22 at 4:25 PM with RN #1 revealed resident #1 had been agitated over the television remote and maintenance had changed the television and remote for resident #2. She stated resident #1 and resident #2 had been roommates for a short time. Resident #1 did not like having roommates, and was territorial. She further stated when the altercation occurred she and CNA #1 immediately removed resident #2 from the room. Resident #2 had a bruise on his/her face and on his/her wrist. She also stated they kept resident #2 at the nurse's station while they moved his/her belongings to another room. f. Review of the care plan for resident #1, with a revision date of 5/9/22, showed the resident displayed behaviors such as hitting staff, suicidal ideation, and resisting cares. Interventions included .observe behavior episodes and attempt to determine underlying cause .document behavior and potential causes . The care plan failed to show resident-specific non-pharmacological interventions for identifying and preventing an escalation of behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Interview on 5/18/22 at 12:24 PM with the DON revealed resident #1 had roommates in the past and there was not a problem. She stated resident #1 used to live in the main area, however s/he had violent behaviors towards staff and tried to elope. She stated they tried to transfer him/her to the psychiatric hospital, however they refused to take him/her. She stated since resident #1 had been in the secure unit his/her behaviors had diminished, s/he participated in activities, ate meals in the common area, and had a friend. She stated when resident #2 returned to the facility from the hospital, they placed him/her in the secure unit and the only available room was with resident #1. She further stated after the 5/3/22 incident, she talked to resident #1 who told her s/he did not want any roommates and s/he would hurt any further roommates. The DON also stated after the incident they initiated 15 minute checks, but as soon as resident #2 was transferred to another room, resident #1 was happy and had not displayed any agitation since.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38149 Based on medical record review and staff interview, the facility failed to ensure when antipsychotic medications were ordered for prn use, the order was discontinued after no more than 14 days, or a new order was written after a direct examination by the attending physician for 1 of 1 residents (#1) reviewed for prn antipsychotic medications. The findings were: 1. Review of the 5/4/22 quarterly MDS assessment for resident #1 showed the resident was admitted on [DATE] with diagnoses which included metabolic encephalopathy, Alzheimer's disease, cognitive communication deficit, and unspecified dementia with behavioral disturbance. The resident had severe cognitive impairment with a BIMS score of 4 out of 15. The resident also had physical and verbal behavioral symptoms on 1 to 3 days during the look back period. Review of the progress note dated 5/3/22 and timed 1:45 PM showed an administration note for Haldol (also known as haloperidol, an antipsychotic medication) given due to the resident acting belligerent and hitting his/her roommate. The following concerns were identified: a. Review of the May 2022 MAR showed an order for Haloperidol tablet give 2 mg [milligrams] by mouth every 12 hours PRN [as needed] for behaviors/danger to self or others. Further review showed the medication was ordered on 12/1/21 and there was no stop date indicated on the order. b. Review of the Medication Regimen Review dated 12/21/21 showed a note from the pharmacist to the physician asking for a review of the PRN Haloperidol (Haldol) order, due to the order being over 14 days old. The physician wrote a note, which was dated 1/4/22, to continue the prn Haldol, still necessary to prevent harm to others need to review in GDR [gradual dose reduction]. Further review of the medical record failed to show any evidence the physician examined the resident and documented the rationale and timeframe needed for a renewed PRN Haldol order. c. Review of the psychotropic medication management review dated 12/21/21 showed Haldol 2 mg every 12 hours PRN behaviors/danger to self and others was reviewed. The recommendations, which were signed by the physician on 12/21/21 showed Continue Haldol prn risks greater than benefit for when patient danger to self or others. Further review failed to show a time frame defined for the continued use of the medication. d. Medical record review failed to show a direct examination of the resident by the physician for the continued use of the PRN medication in December 2021. e. Interview on 5/17/22 with the social worker stated they review medications at the gradual dose reduction meetings and psychotropic medication management reviews, which were held quarterly. The social worker further stated the physician saw residents monthly.