STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laramie Health and Rehabilitation	**503 S 18th St , Laramie, Wyoming, 82070**

(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 5/31/26 to 6/3/26. Also reviewed in the course of the survey were complaint intakes #2963672, #2982804, and #2712358. The following common abbreviation are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CMA: Certified Medical Assistant CNA: Certified Nursing Assistant DON: Director of Nursing PBJ: Payroll Based Journal RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		06/26/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary	F0600	"Past Noncompliance - no plan of correction required"	06/26/2026

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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F0600 SS = G	Continued from page 1 seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, medical record review, and facility investigation and policy review, the facility failed to protect the residents' right to be free from physical abuse by other residents for 1 of 5 sample residents (#3) reviewed for allegations of abuse and neglect, which resulted in actual harm to resident #3. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 4/9/26. 1. Review of the quarterly MDS assessment dated 3/26/26 showed the BIMS assessment for resident #3 wasn't able to be completed which indicated severe cognitive impairment, and included diagnoses of chronic obstructive pulmonary disease, Parkinson's disease, and dementia. Review of the quarterly MDS assessment dated 5/11/26 showed resident #11 had a staff assessment of mental status which indicated severe cognitive impairment for daily decision making, and included diagnoses of Alzheimer's disease, dementia with severe agitation, and anxiety. Review of the care plan dated 2/11/26 showed resident #11 had a history of behaviors which included agitation, grabbing, hitting, kicking and being physically aggressive towards others, and interventions of redirection, one to one staff monitoring, reassurance and ensuring resident safety. The following concerns were identified: a. Review of the facility investigation dated 3/29/26 showed resident #11 had attempted to push resident #3's wheelchair. When resident #3 told him/her to stop, resident #11 hit resident #3 in the face multiple times with a closed fist. Resident #3 put his/her arms up in defense and resident #11 then grabbed the resident's oxygen tubing and attempted to put it around resident #3's neck. Facility staff intervened before injury with the oxygen tubing occurred. The residents were separated and assessed for injury, which showed resident #11 had red knuckles with a break in the skin and resident #3 had redness to the cheek area. Resident #11 was placed on 1 to 1 observation until the interdisciplinary team could assess the resident's needs. Following the incident, the staff on duty had been provided with re-education on behavioral interventions to use if resident #3's demonstrated behaviors. b. Interview with hospitality aid #1 on 6/3/26 at 10:23 AM confirmed when she arrived on shift	F0600		06/26/2026

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F0600 SS = G	Continued from page 2 resident #11 had been drinking out of a flower vase and became agitated after it was taken away. S/he then walked with him/her down the hallway and when they walked by resident #3, resident #11 punched resident #3, grabbed the oxygen tube and attempted to wrap it around resident #3's neck. Hospitality aide #1 put her hands in between the tubing and resident #3's neck. The residents were separated and resident #3 had a red cheek from being punched. c. Interview with the DON on 6/03/26 at 10:48 AM revealed she had assessed both residents after the incident and found resident #3 had redness to his/her face, and resident #11 had redness and broken skin to his/her knuckles. She confirmed resident #11 had not had any additional resident to resident aggressions since this incident. d. Review of the facility policy titled "Freedom from abuse, neglect, corporal punishment, involuntary seclusion, mistreatment, misappropriation of resident property, and exploitation" showed "Each resident has the right to be free from abuse…The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members, and others who may have unsupervised access to residents…" 2. The facility implemented the following corrective action by 4/9/26: a. A 1:1 was placed on resident #11; b. Resident safety interviews were conducted; c. Education to all staff on abuse was completed on 4/1/26; d. The facility implemented audits; and e. The incident was discussed in quality assurance on 4/9/26 and the results of audits are monitored through quality assurance.	F0600		06/26/2026
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F0725	Staffing schedules were reviewed to validate compliance. DON/Designee reviewed the Facility Assessment to validate accuracy of HPPD, updates made as needed related to HPPD and need for staffing. Facility schedules updated to validate appropriate staffing. Accurate coding of staff to reflect correctly in the PBJ updated.	07/10/2026

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F0725 SS = F	Continued from page 3 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of the resident council notes, resident interview, staff interview, review of the "Facility Assessment" dated 12/11/25, PBJ staffing data report review, review of worked staff schedule 10/1/25 through 12/21/25, and review of the "Declaration of Nursing Staffing" sheets, the facility failed to ensure adequate staff were provided to meet the needs of the residents. The findings were: Review of the facility assessment with a completion date of 12/11/2025 showed for short stay, the average number of residents admitted within past 6 months was 48. The average number discharged within the past 6 months was 45. The long-stay average number of residents admitted within the past 6 months was 29. The average number of residents discharged within the past 6 months was 37. Further review showed the "Hours Per a Resident Days" (HPRD) Day - RN 32, LPN 54, CNA/STNA 75, Nights - RN 32, LPN 54, CNA/STNA 75.	F0725	Continued from page 3 ED/Designee educated staff on compliance for Staffing HPPD and maintaining HPPD per the Facility Assessment. DON/Designee will audit staffing 5x per week for 3 months to validate Staffing HPPD is maintained according to the Facility Assessment. DON/Designee will report on the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0725 SS = F	Continued from page 4 Interview with the DON on 6/3/26 at 3:31 PM revealed when she staffs the schedule it was 2 day shift nurses, 2 night shift nurses, and a minimum of 2 CNAs per station during the day and night shifts, then 1 CNA per station during the overnight 10 PM through 6 AM shift (the facility only had 2 stations). She stated she was unaware of the hours needed for staffing from the Facility Assessment. The following concerns were identified: 1. Observation on 5/31/26 upon entry to the facility showed only 1 CNA was seen in the front hall. 2. Review of PBJ Staffing Data Report for FY Quarter 1 2026 (October 1, 2025 - December 31,2025) showed Excessively Low Weekend Staffing triggered. 3. Review of the October – December 2025 staff worked schedules showed the following concerns. a. Review of October 2025 worked schedule showed the shortage of CNAs on the following dates. - On Saturday, 10/11/25 from 2PM - 6PM the facility only had 2 CNAs on duty. - On Sunday, 10/12/25 from 6AM – 10AM the facility only had 2.5 CNAs on duty. - On Friday, 10/31/25 from 6PM – 10PM the facility only had 2.5 CNAs on duty. b. Review of the November 2025 worked schedule showed the shortage of CNAs on the following dates. - On Friday, 11/7/25, from 6AM-10AM the facility only had 3 CNAs on duty and then from 2PM – 10 PM the facility had only 2 to 2.5 CNAs on duty. - On Sunday, 11/9/25 from 6AM – 10AM the facility only had 2.9 CNAs on duty. - On Friday, 11/14/25 from 2PM – 10PM the facility only had 2 to 2.5 CNAs on duty - On Saturday, 11/15/25 from 2PM – 6PM the facility only had 3 CNAs on duty - On Friday, 11/21/25 from 6AM – 10AM and 6PM – 10PM the facility only had 3 on duty.	F0725		07/10/2026

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F0725 SS = F	Continued from page 5 - On Saturday, 11/22/25 from 10AM – 6PM 3 CNAs and 6PM – 10PM 2.5 CNAs were on duty. - On Sunday, 11/23/25 from 6AM – 10AM and 6PM – 10 PM the facility only had 3 CNAs on duty. - On Friday, 11/28/25 from 10PM – 6AM the facility only had 1 CNA on duty. - On Saturday, 11/29/25 from 2PM – 10PM the facility only had 3 CNAs on duty. - On Sunday, 11/30/25 from 6AM – 10AM and 6PM – 10PM the facility only had 3 CNAs on duty. c. Review of the December 2025 worked schedule showed the shortage of CNAs on the following dates. - On Saturday, 12/6/25 from 6AM – 2PM the facility only had 2 CNAs on duty, and from 10PM – 6AM the facility only had 1 CNA on duty. - On Sunday, 12/7/25 from 6AM – 2PM the facility only had 2 CNAs on duty and from 2 PM – 6 PM only 3 CNAs were on duty. - On Friday, 12/12/25 from 6AM – 6PM the facility only had 3 CNAs on duty, and from 6PM – 10PM on 2 CNAs were on duty. - On Saturday, 12/13/25 from 6PM – 10PM the facility only had 2 CNAs on duty, and from 10PM – 6AM only 1 CNA was on duty. - On Sunday, 12/14/25 from 6PM – 10PM the facility only had 2 CNA on duty. - On Friday, 12/19/25 from 6PM – 10PM the facility only had 2 on duty. - On Saturday, 12/20/25 from 10PM – 6AM the facility only had 1 CNA on duty. - On Sunday, 12/21/25 from 6AM – 6 PM the facility only had 3 CNAs on duty, and from 6PM – 10PM only 2 CNAs on duty. - On Friday, 12/26/25 from 2PM – 6PM only 2 CNAs on duty, from 6PM – 10PM only 3 CNAs on duty. Then from 10PM – 6AM only 1 CNA was on duty. - On Saturday, 12/27/25 from 2PM – 6PM only 3 CNAs were on duty, and then from 6PM – 10PM only 2 CNAs were on duty.	F0725		07/10/2026

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F0725 SS = F	Continued from page 6 4. Review of the 5/25/26 through 5/31/25 "Declaration of Nursing Staffing" showed the following concerns: - On 5/25/26 from 6AM - 6PM only 3 CNAs were on duty. - On 5/26/26 from 6PM – 10 PM only 3 CNAs were on duty. - On 5/27/26 from 6PM – 10PM only 3 CNAs were on duty. - On 5/28/26 from 2PM – 10PM only 3 CNAs were on duty. - On 5/29/26 from 6PM – 10PM only 3 CNAs were on duty. - On 5/30/26 from 6AM – 6PM only 1 CNA was on duty, and then from 6PM – 10PM only 2 CNAs were on duty. - On 5/31/26 from 6AM – 10AM only 2 CNAs were on duty, then from 10AM – 6PM only 1 CNA was on duty, and then from 6PM – 10 PM only 3 CNAs were on duty. 5. Interview with the resident council on 6/1/26 at 1:28 PM revealed they felt the long call light times and delayed or missing food delivery was due to low staffing. 6. Interview with resident #40 on 6/1/26 at 11:19 AM revealed s/he felt there was not enough staff. S/he stated when they only had 1 person covering any length of time, it was not enough staff. 7. Interview with resident #5 on 6/2/26 at 11:44 AM revealed s/he felt the facility was short on CNAs. S/he stated that it takes a long time for them to answer call lights. S/he stated they are so busy that s/he does not get his/her clothing changed for 2 to 3 days. 8. Interview with CNA #2 on 6/3/26 at 9:29 AM revealed she felt low staffing is an issue and felt like scheduled staff called out frequently. She reported feeling overwhelmed.	F0725		07/10/2026

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F0725 SS = F	Continued from page 7 9. Interview with the DON on 6/3/26 at 3:31 PM revealed she did the staff schedule for the nursing staff. She stated the PBJ was connected with the facility system. So, it would automatically fill in the required field, and Corporate oversees the PBJ system.	F0725		07/10/2026
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. §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.	F0628	Residents #6, #23, #30, and #31 had transfer/discharge notice documentation reviewed and corrected as appropriate. DON/Designee completed an audit of recent transfers, and discharges from the last 30 days to validate required notices were provided and documented; corrections made as needed. DON/Designee educated Staff on timely transfer/discharge notification requirements to validate compliance. DON/Designee will audit transfers and discharges weekly for 3 months to validate compliance. ED/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0628 SS = E	Continued from page 8 (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 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	F0628		07/10/2026

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F0628 SS = E	Continued from page 9 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 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,	F0628		07/10/2026

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F0628 SS = E	Continued from page 10 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 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 review, the facility failed to provide a notice of transfer/discharge prior to a facility-initiated hospital transfer for 4 of 5 sample residents (#6, #23, #30, #31). The findings were: 1. Review of the medical record showed resident #6 was transferred to the hospital on 3/19/26. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident	F0628		07/10/2026

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Laramie Health and Rehabilitation	**503 S 18th St , Laramie, Wyoming, 82070**

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F0628 SS = E	Continued from page 11 and/or the resident representative 2. Review of the medical record showed resident #23 was transferred to the hospital on 2/10/26. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. 3. Review of the medical record showed resident #30 was transferred to the hospital on 2/27/26. Further review showed no evidence the facility had issued a written transfer/discharge notice to the resident and/or the resident representative. 4. Review of the medical record showed resident #31 was transferred to the hospital on 5/21/26 and 5/24/26. Further review showed no evidence the facility had issued written transfer/discharge notices to the resident and/or the resident representative. 5. Interview with the DON on 6/03/26 at 12:05 PM revealed the "Interact" form was sent with the residents when they were transferred to the hospital, and the resident or their representatives were provided with the bed hold information. Further interview confirmed residents or their representatives were not provided with a written transfer/discharge notice. 6. Review of the policy titled "Transfer and Discharge" and updated May 2025 showed "...5. When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the includes the [sic] following items: a. Date notice is given, b. Effective date of the transfer/discharge. c. Reason for the transfer/discharge. d. Where the resident is to be moved. e. Contact information for the State Long-Term Care Ombudsman..."	F0628		07/10/2026
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure bathing was performed per the plan of care for 2 of 3 residents (#31, #59) reviewed for bathing. The findings were:	F0677	Residents #31 and #59 received showers according to their preference. DON/Designee completed an audit of residents' bathing preferences; corrections made as needed. DON/Designee educated Nursing staff on following the residents' bath preferences and documenting refusals. DON/Designee will audit bathing documentation weekly for 3 months to validate compliance.	07/10/2026

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F0677 SS = E	Continued from page 12 1. Review of the admission MDS assessment dated 4/7/26 showed resident #31 admitted to the facility on 4/7/26. Review of the care plan last revised on 4/13/26 showed the resident required maximum assistance from staff for bathing. Review of the care plan last revised on 5/26/26 showed “Bathing Schedule/Frequency: prior to hospitalization [s/he] showered every other day.” The following concerns were identified: a. Observation on 5/31/26 at 4:24 PM showed the resident wore a hospital gown and wrap around brief, was in bed, and hair appeared greasy and uncombed. b. Review of the bathing log provided by the DON showed the resident preferred bathing on Tuesday and Friday afternoons, and had been provided with a bed bath on 5/6, 5/18, and 5/26. The resident refused on 5/12, and “activity did not occur” on 5/15 and 5/19. 2. Review of the medical record showed resident #59 admitted to the facility on 3/25/26. S/he discharged to the hospital on 4/13/26, returned on 4/21/26, and discharged to the hospital again on 5/14/26, and returned on 5/27/26. Review of the care plan last revised on 5/6/26 showed the resident was at risk for ADL self-care performance deficit related to amputation, impaired balance and pain, and may at time refuse cares and showers. S/he required maximum assistance of 1 person for bathing, and staff was to encourage the resident to bathe on scheduled shower days. The following concerns were identified: a. Observation on 5/31/26 at 2:45 PM showed resident #59 wore a hospital gown and had long hair that appeared greasy and uncombed. Continued observation on 6/1/26 at 11:31 AM showed the resident’s hair continued to appear greasy and uncombed. b. Review of the bathing log provided by the DON showed the resident preferred showers on Tuesday and Friday afternoons, and had been provided with a shower on 4/29/26, 5/8/26 and 5/9/26. The resident refused a shower on 5/12/26. 3. Interview with CNA #3 on 6/2/26 at 4:34 PM revealed there were no scheduled shower aides, and the CNAs were expected to bathe the residents. Further interview revealed it had been “tricky” to get any showers done because it had been a “crazy” day, and when the residents did not receive baths, it	F0677	Continued from page 12 DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0677 SS = E	Continued from page 13 was “not usually due to their refusals.” 4. Interview with the DON on 6/3/26 at 4:43 PM revealed if residents refused a shower, she expected staff to reapproach with a different staff member or nurse. She stated every refusal should be charted, and she had implemented a plan to improve documentation in general, which included a current PIP for bathing. She reported she had started to keep bathing charts at the unit desks in February 2026. She confirmed the facility did not use bath aides, and the expectation was that CNAs and nurses provided bathing for the residents.	F0677		07/10/2026
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident, staff, and representative interviews, medical record review, and activity calendar review, the facility failed to ensure individual activities of preference were provided to 4 or 4 sample residents (#4, #8, #23, #30) , and weekend activities were provided to 5 of 5 sample residents (#4, #8, #23, #30, #40) reviewed for activities. This was verified at the confidential resident council meeting. The findings were: Regarding activities of preference 1. Review of the care plan last revised 10/6/25 showed resident #4 had interventions for psychosocial well-being and one-to-one. The following concerns were identified: a. Interview with the resident on 6/1/26 at 10:28 AM revealed the activities were for “young kids and not old adults,” therefore s/he did not participate. S/he did participate in resident council when s/he was told about it.	F0679	Residents #4, #8, #23, #30, and #40 identified had activity assessments, preferences, and participation plans reviewed and updated as needed. Activities Director/ Designee completed an audit of residents not attending group activities to validate individualized and meaningful activities were provided and documented including weekends and evenings; updates were made as needed. ED/Designee educated activities staff on meaningful engagement, individualized programming, and documentation requirements. ED/Designee will audit activity participation records weekly for 3 months to validate compliance. DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0679 SS = E	Continued from page 14 b. Interview with the Social Worker on 6/2/26 at 3:09 PM revealed the resident had not participated in activities since s/he was admitted to the facility. She stated the resident would occasionally come out of his/her room and talk with staff. c. Review of the activity participation logs showed the resident participated in independent activities 58 out of 94 opportunities, and one-to-one activities 1 out of 94 opportunities. There was no documented activity participation on weekends. 2. Review of the care plan for resident #8, initiated on 11/13/25 showed activity staff would escort him/her to and from activities and provide one-to-one visits twice weekly. The following concerns were identified: a. Review of the activity participation log showed resident #8 had participated in one-to-one 2 out of 94 opportunities. The resident was documented as participating in independent activity 51 out of 94 opportunities and group activity 2 out of 94 opportunities. There was no documented activity participation on weekends. 3. Review of the care plan last revised 1/15/26 showed resident #23 would be out of his/her room daily to avoid self-isolation. a. Interview with resident #23 on 6/1/26 at 12:01 PM revealed "there's nothing to do here." b. Observations throughout the survey showed the resident did not leave his/her room. c. Review of the activity participation logs showed the resident participated in independent activities 55 out of 94 opportunities, group activities 1 out of 94 opportunities and one-to-one activities 4 out of 94 opportunities. There was no documented activity participation on weekends. d. Interview with the activity director on 6/3/26 at 4:05 PM revealed the resident went to group music activities 2 to 3 times per month, and other than that, s/he liked to use his phone, watch movies, have conversation or do his/her shaving and hair. 4. Review of the care plan last revised on 10/6/25 showed resident #30 identified “keeping my hands busy" as important. Interventions initiated on 3/3/26 showed to include one-to-one visits 3 times per week. The following concerns were identified: a. Observations throughout the survey showed the	F0679		07/10/2026

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F0679 SS = E	Continued from page 15 resident was in bed, sitting in a wheelchair by the nurses' station, and sitting in the dining room. The resident was not observed in activities. b. Review of the activity participation log showed the resident had participated in one-to-one 3 out of 94 opportunities. The resident was documented as participating in independent activity 49 out of 94 opportunities and group activity 10 out of 94 opportunities. There was no documented activity participation on weekends. c. Interview with the resident representative on 6/3/26 at 11:11 AM revealed the resident did not participate in many activities, and s/he liked to do things with his/her hands. d. Interview with the activity director on 6/3/26 at 4:09 PM revealed the resident participated in trivia, bingo, people watching and snacks. She reported s/he liked to walk around with a one-to-one, and she put the resident in an activity to watch a movie and have coffee. She stated she documented one-to-one as independent in her documentation. 5. Interview with the activity director on 6/2/26 at 4:01 PM revealed she did one-to-one visits if residents did not participate in the group activities, and she chatted and did their nails and usually provided a snack. She charted through POC in Point Click Care (PCC) and she did rounds in the morning to assesses what activities residents wanted to do for the day. Further interview revealed she had been the activity assistant and she worked as a director under the activity director of another facility while she waited to take the course to be a director. Regarding weekend activities 1. Observation on 5/31/26 at 2:30 PM showed 2 residents independently played a trivia game on the TV in the activity room. No staff was present in the room. 2. Review of the activity participation logs showed no weekend activity participation for residents. 3. Review of the "Weekly Activity Agenda" showed no activities scheduled for the weekend. 4. Interview with resident #40 on 6/1/26 at 10:50 AM revealed there was not an activity assistant to help with the activity program, and there was no one to assist on the weekend. S/he had to wait for people who walked by to change stations on the TV and	F0679		07/10/2026

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F0679 SS = E	Continued from page 16 push the buttons for the games on the TV. 5. Interview with the supervising activity director on 6/3/26 at 8:53 AM revealed the expectation was for one-to-one activities to be resident directed, and if they had no interest she expected the activity personnel to visit and talk to the residents. She stated goals should be resident specific and added to the care plan on admission, and the need for independent activity should be communicated in the care plan. Further interview revealed they needed to provide activities 7-days a week, and they should have weekend staff for activities. She revealed the activity director needed assistance, and it was hard for her to update the MDS assessments and care plans because she always had to catch up with documentation. She confirmed weekend activities were self-directed and the manager on duty should help engage residents with activities on the weekend. 6. Interview with the DON on 6/3/26 at 4:43 PM revealed a support nurse was supposed to help with activities on the weekend, but she did not know how much they were able to help or if they documented any activities. 7. Review of the policy titled “Activity Program” updated July 2015 showed “…1. The activity program: a. Is multifaceted to reflect the entire resident population’s needs and interests. b. Is varied to provide stimulation or solace. c. Promotes physical, cognitive, and/or emotional well-being. d. Enhances to the extent practical each resident’s physical, mental, and psychological status. e. Encourages self-respect through activities that support self-expression and choice. f. Meets applicable state and federal guidelines. g. Reflects individual resident evaluations as well as MDS assessments…6. Activities are offered at a variety of times to reflect resident’s scheduling needs and preferences…”	F0679		07/10/2026
F0800 SS = E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by:	F0800	Residents #4, #41, #40, #23, and #47 concerns regarding food quality, menu accuracy, and meal service timing were reviewed, and corrective actions implemented. FANS Manager/Designee completed an audit of meal service times, menu accuracy and resident food preferences; updates made as needed. An action sheet was added to the food committee to document interventions and action for follow up of concerns.	07/10/2026

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F0800 SS = E	Continued from page 17 Based on observation, resident interview, staff interview and review of meeting notes and grievance documentation, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration resident preferences. The census was 58. The findings were: 1. Observation on 5/31/26 at 2 PM showed resident lunch meal trays were being delivered. 2. Interview with resident #4 on 6/1/26 10:28 AM revealed that the food that was delivered was not always what was listed on the menu, at times s/he could not tell what the food had been, the temperature could be extreme hot and cold, and most times portions were small. 3. Interview with resident #41 on 6/1/26 at 10:07 AM revealed that the “food is a 3/10”, and included a lot of canned veggies and potato or rice. In addition, the food tasted bland and boring, and the same food was repeated frequently. The resident also reported s/he was not always able to identify the food by looking at it or tasting it. 4. Interview with resident #40 on 6/1/26 at 10:50 AM revealed he food was "pretty bland" and the room trays were not hot. 5. Interview with resident #23 on 6/1/26 at 12:07 PM revealed the facility ran out of food frequently, the food they are served is “lousy”, and s/he wanted different choices on beverages. 6. Interview with resident #47 on 6/1/26 at 1:28 PM revealed s/he had late meal trays, and s/he had not turned in any grievances because when s/he did they just told her/him it didn’t happen. S/he reported s/he had to go looking for her/his meal tray that day at 1 PM because it had not been delivered yet and the meal had been found in a unmanned cart in the dining room. 7. Interview with the resident council on 6/1/26 at 1:28 PM revealed the residents had often complained of food quality, resident preferences not being followed and late timing of trays. These topics had also been discussed at the food committee meetings. They also revealed the residents had often decided to not fill out grievance forms regarding food because they felt they were not being looked into appropriately and they did not hear back on the resolution every time.	F0800	Continued from page 17 FANS Manager/Designee educated Dietary staff on meal quality, menu compliance, meal service timeliness, and resident preferences. ED/Designee will audit meal service weekly for 3 months to validate compliance. DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0800 SS = E	Continued from page 18 a. Review of the resident council minutes for March, April and May of 2026 showed new incidents of complaints of food timing and palatability were discussed at every meeting. 8. Review of the March, April and May of 2026 grievance log showed there were 15 grievances related to food, which included 11 for late and missing trays, and 4 for food quality. Five grievances were filled out by the resident's family members that had to go find the food trays for the residents to get their meals. Grievance resolutions showed staff checked meal pass time documentation and reviewed that they had been passed out within the allotted time frame and considered those grievances unfounded. There was no evidence of pattern tracking or meal time observation. Food preferences were reviewed with residents on grievances with quality of meal and there was no evidence of food quality review. 9. Review of resident food committee meeting notes for March, April, and May of 2026 showed food quality, palatability, temperature, late meal trays, snack options, and food preferences not always being followed were being discussed with no evidence of dietary staff's changes or interventions to improve resident experiences. 10. Interview with the dietary manager on 6/3/26 at 2:12 PM confirmed she had been aware of the concern for meal tray timing and food quality and reported interventions had been adjusted but had no documentation of it. She had been running the food committee meetings and could not provide any documentation of new interventions or system changes that she had implemented to improve delays and quality.	F0800		07/10/2026
F0577 SS = D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	F0577	Survey Postings were immediately placed in the survey results binder located in the public area to meet compliance. ED/Designee completed an audit of survey postings to validate no additional survey results binders exist and required documents were available; no additional concerns were identified. ED/Designee educated Nurse Admin staff on requirements for maintaining current survey results in a publicly accessible location for compliance. ED/Designee will audit the survey results binder monthly for 3 months to validate compliance.	07/10/2026

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F0577 SS = D	Continued from page 19 §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, and staff interview, the facility failed to ensure recertification and complaint survey reports, and any plans of correction, during the 3 preceding years, were available for any individual to review upon request. The findings were: 1. Observation on 5/31/26 at 3:20 PM showed the State Survey binder had a document stating "State Surveys Public Record 1 year". The other documentation dated on 2/24/26 was the iQIES (Internet Quality Improvement and Evaluation System) ePOC (Electronic Plan of Correction), and a complaint survey 2567 dated on 2/12/26. Inside of front binder was a piece of tape showing updated 2/26/26. There was no notice of prior surveys. Further observation showed above the binder holder on the wall was a framed notice showing "State Surveys & Plan of Corrections, Three years of Results." 2. Interview with the administrator on 6/1/26 at 9:00 AM revealed she was unaware that the last standard survey needed to be posted in the binder as well.	F0577	Continued from page 19 ED/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F0585	Residents identified #4, #40, #47, and #15 grievances were reviewed and updated/reopened and resolved as needed to validate compliance timely. ED/Designee audited the Grievance Process; any new identified grievances were documented on	07/10/2026

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F0585 SS = D	Continued from page 20 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 20 a grievance form and resolved in a timely manner. ED/Designee educated staff on the grievance process to validate grievances are documented on a grievance form and resolved in a timely manner. ED/Designee will audit the grievance processes weekly for 3 months to validate compliance. ED/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2026

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F0585 SS = D	Continued from page 21 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to properly obtain grievances and maintain evidence demonstrating the appropriate action and issuance of the grievance decision for 4 of 8 residents (#4,#40,#47,#15) reviewed for grievances. The findings were: 1. Interview with resident #4 on 6/1/26 at 10:28 AM revealed the resident had asked staff multiple times to replace a cloth recliner that had stuffing falling out of the armrest. S/he also had been told by the maintenance director that his/her personal large-screen TV had been hit by lightning, and it was replaced with a “tiny” TV. The large TV had also been removed from his/her room by maintenance and s/he does not know what happened to it. Further interview revealed s/he had reported clothing and a blanket were missing, but	F0585		07/10/2026

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F0585 SS = D	Continued from page 22 s/he did not fill out a grievance because “nothing was done” when s/he filled them out. a. Observation on 6/1/26 at 10:28 AM showed a recliner in the resident’s room had a torn right arm and exposed stuffing. Further observation showed one small TV, and no evidence of a large TV. b. Interview with the infection control nurse on 6/3/26 at 11:56 AM revealed she had been aware aware of resident #4’s chair falling apart and considered it to be an infection control risk. She had offered alternative chairs to the resident, but did not fill out a grievance and did not have documentation of her attempts to resolve the issue. c. Interview with the maintenance director on 6/03/26 at 12 PM revealed he was aware of resident #4’s broken chair and had offered other chairs and they were not to the resident’s liking and refused to have the broken one removed. Further interview showed he had been aware of the large TV in the resident’s room being broken and had set up a smaller, working TV for the resident. He reported he expected the large TV to have been left in the resident’s room, and did not know it had been removed. Further interview revealed he had no documentation of either situation and did not fill any grievances out himself. He confirmed past records for maintenance had been lost in October 2025 after change of ownership. d. Interview with the DON on 6/03/26 at 12:31 PM revealed she had been unable to find a grievance or any documentation on the resident’s recliner or missing TV. She expected grievances to be filled out by resident or staff if the resident declined to fill one out for themselves. She confirmed there were missing maintenance records after the previous maintenance supervisor left the position with changed ownership. 2. Interview with the resident council on 6/1/26 at 1:28 PM revealed the residents had often decided to not fill out grievance forms because they felt they were not being looked into appropriately and they did not hear back on the resolution every time. They reported the facility addressed some of the grievances individually but did not address the root cause of frequent. similar complaints. a. Review of the resident council minutes for March, April and May 2026 showed new incidents of missing clothing/items and complaints of food timing and palatability were addressed at every meeting.	F0585		07/10/2026

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F0585 SS = D	Continued from page 23 b. Review of the March, April and May of 2026 grievance log showed there were 15 grievances related to food, which included 11 for late and missing trays, and 4 for food quality. 5 grievances were filled out by the resident's family members that had to go find the food trays for the residents to get their meals. Grievance resolutions showed staff checked meal pass time documentation and reviewed that they had been passed out within the allotted time frame and considered those grievances unfounded. No evidence of pattern tracking or meal time observation. Food preferences were reviewed with residents on grievances with quality of meal and no evidence of food quality review. c. Review of grievances from March, April and May of 2026 showed 2 grievances on missing clothing, one had been resolved with replacement of the clothes and one unresolved but closed as completed. 3.Interview with resident #40 on 6/1/26 at 11:44 AM revealed s/he had missing clothing items, and s/he did not turn in a grievance form because the clothes were not replaced so it didn't make a difference. 4.Interview with resident #47 on 6/1/26 at 1:28 PM revealed s/he had late meal trays, and s/he did not turn in any grievances because when s/he does they just tell her/him it didn't happen. S/he had walked to the dining room at 1PM because it had not been delivered and found it in a unmanned cart in the dining room. 5.Interview with resident #15 on 6/1/26 at 1:44 PM revealed s/he had missing clothing items, and s/he did not turn in a grievance form because the clothes were not replaced and s/he felt it didn't make a difference and it just kept happening. S/he reported when s/he had been offered new clothing to replace missing clothing, s/he had not been given a choice of clothing s/he liked. 6. Interview with the administrator on 6/2/26 at 3:28 PM revealed the expectation for grievance reporting had been for residents to fill them out at the time of incident. Staff should offer to fill it out with them, if the resident declined, the staff should fill one out on the resident's behalf. 7. Review of the facility policy titled "Grievance Procedure Policy" showed "...6.grievances are resolved immediately, when possible, by the individual receiving the grievance. The individual receiving the grievance fills out the Grievance Form. 7. When immediate resolution is not possible, the	F0585		07/10/2026

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F0585 SS = D	Continued from page 24 grievance is routed to the Grievance Official promptly…10. The person with the grievance has a right to a written decision regarding his/her grievance…The administrator analyzes grievances monthly for tracking and trending…"	F0585		07/10/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interview, and review of investigation documentation, the facility failed to ensure a thorough investigation of an allegation of physical abuse for 1 of 5 sample residents (#47). The findings were: 1. Review of the facility's investigation documentation showed an allegation of physical abuse involving residents #47 and #30 was reported on 5/14/26. The facility did investigate and placed a 1:1 on the perpetrator right away. The perpetrator room was changed to a different hall. The facility did interview others, and staff. The facility did do abuse education with staff. However, the facility failed to assess the victim right away and waited 2 days later to assess for injuries. 2. Review of the MDS quarterly assessment dated 4/11/26 for resident #47 (victim) showed a BIMS score of 12 out of 15 (moderate cognitively impaired). The resident did have verbal behavioral symptoms	F0610	Residents #47 and #30 were reviewed to validate immediate and ongoing safety. ED/Designee completed an audit of abuse investigations in the previous 30 days to validate compliance; corrections were made immediately if found/applicable. A checklist was created to validate compliance. ED/Designee educated nurses on completing head-to-toe skin assessments on residents involved in abuse investigations. ED/Designee will audit abuse investigations weekly for 3 months to ensure compliance. ED/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026	07/10/2026

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F0610 SS = D	Continued from page 25 directed towards others. S/he had diagnosis including medically complex conditions, type 2 diabetes mellitus, polyneuropathy chronic pain, and tension-type headache. 3. Review of the MDS significant change assessment dated 3/8/26 showed resident #30 (perpetrator) had memory problem short and long term and did not have behaviors present. The diagnosis included non-traumatic brain dysfunction, dementia without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety, non-Alzheimer's dementia, and age-related cognitive decline. 4. Interview with the victim on 6/2/26 at 3:30 PM revealed the perpetrator was resident #30. S/he stated the perpetrator had motioned for him/her to come over. S/he stated that s/he bent over so s/he could tell him/her something. S/he stated the perpetrator used his/her right hand and grabbed their left buttock. S/he stated it was not welcomed or did not want the touch. S/he stated s/he did report the incident to the social services. 5. Interview with CMA #1 on 6/2/26 at 5:05 PM revealed resident #47 (victim) reported resident #30 (perpetrator) made an inappropriate comment to him/her. He stated he walked resident #47 down to social services. 6. Interview with Social Services #1 on 6/2/26 at 5:13 PM revealed the victim reported to her that the perpetrator wanted him/her to sit on his/her lap (S/he was demonstrating by slapping his/her lap). She stated they put a 1:1 on the perpetrator and did a room change. 7. Interview with the administrator on 6/2/26 at 5:13 PM revealed they made sure the victim was safe. She stated the staff were educated on abuse. She stated the victim had changed his/her story 3 times. She revealed the facility did not do a skin assessment on the victim right away, and the assessment was done 2 days later.	F0610		07/10/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the	07/10/2026

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F0641 SS = D	Continued from page 26 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 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 observation, medical record review, and staff and resident interview, the facility failed to ensure the MDS assessment was accurate in reflecting the resident's status for 1 of 22 sample residents (#10). The findings were: 1. Review of the 5/4/26 quarterly MDS assessment showed resident #10 had a BIMS score of 14 out of 15 (cognitively intact), an indwelling catheter and an ostomy. 2. Observation on 5/31/26 at 3:39 PM showed resident #10 sitting in the resident's room a urinary foley catheter tubing and catheter collection bag was noted. Interview with the resident at that time revealed the staff took care of the catheter and	F0641	Continued from page 26 provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual Resident #10's MDS assessment was immediately corrected to accurately reflect the resident's condition. MDS Nurse/ Designee completed an audit of MDS assessments in the last 30 days in the identified area was completed to validate accuracy; corrections made as needed. DON/Designee educated MDS on assessment accuracy and supporting documentation requirements for compliance. DON/Designee will audit weekly for 3 months to ensure compliance. DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026	07/10/2026

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F0641 SS = D	Continued from page 27 collection bag. S/he revealed s/he only had the urinary catheter. 3. Review of the medical record for resident #10 showed the medical history included neurogenic bladder, and obstructive a reflux uropathy. Further review showed the resident's care plan showed the care for an indwelling urinary catheter. Review of the physicians' orders showed Suprapubic catheter sized 16 F (French) balloon: 10cc (cubic centimeter), as needed damage, occlusion, or obtaining UA (Urinalysis) dated 2/2/26. Further review showed no mention of an ostomy. 4. Interview with the MDS Coordinator on 6/2/26 at 3PM revealed PCC (Point Click Care) automatically pulls the ostomy information into the system. She stated she did not catch it. She stated the system did not pull from the RAI, it pulled from any evaluations within the system. She confirmed it was an MDS error. and she would do a modification on it right away. She stated there was no policy that she was aware of. She stated it was their policy is to follow the RAI manual.	F0641		07/10/2026
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F0732	Daily staff posting information was immediately updated and posted in the designated location. DNS/Designee immediately updated the process for printing the information to meet compliance. ED/Designee educated nursing leadership on posting requirements and monitoring expectations. ED/Designee will audit required postings weekly for 3 months. DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026.	07/10/2026

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F0732 SS = D	Continued from page 28 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, and staff interview the facility failed to ensure the daily staff posting data was posted in a prominent place readily accessible to residents, staff, and visitors for 1 of 4 days (Sunday). The findings were: Observation on 5/31/26 at 3:18 PM showed there was no daily staff data sheet posted. Interview with the DON on 5/31/26 at 4:45 PM revealed the facility failed to post the daily staff posting data sheet for the day.	F0732		07/10/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	Resident #8, was assessed by staff to validate immediate infection control safety was practiced. Staff identified during survey received immediate	07/10/2026

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F0880 SS = D	Continued from page 29 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, 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	F0880	Continued from page 29 education by the DON/Designee and return demonstration regarding infection control practices and proper disinfection procedures to meet IC compliance for wound care. DON/Designee educated staff on infection prevention to validate IC compliance for wound care. DON/Designee will randomly audit wound care dressing changes weekly for 3 months to validate infection control practices are followed. DON/Designee will report on the tracking and trending of the audit to the facility's monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Compliance Date: 7/10/2026	07/10/2026

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F0880 SS = D	Continued from page 30 (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. §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 and policy and professional standards review, the facility failed to ensure standard precaution implementation and semi-critical items were cleaned prior to use for 1 of 8 sample residents (#8) reviewed for infection control. The findings were: 1. Observation on 6/2/26 at 10:40 AM showed RN #2 and the wound care nurse had entered resident #8's room to clean the resident of incontinence and complete wound care. The following concerns were identified: a. RN #2 donned gloves and a gown and cleaned the resident of stool. She then moved to the other side of the bed to hold the resident on his/her side for the wound nurse to provide care without doffing her dirty gloves. b. The wound care nurse donned gloves and a gown and held the resident on his/her side while incontinence care was performed then moved to the other side of the bed to perform wound care on an open sacral pressure ulcer. He opened a calcium alginate dressing and had a coworker get his scissors out of his pocket, used them to cut the dressing to wound size and then placed them back in his pocket. 2.Interview with the wound care nurse on 6/3/26 at 3:48 PM confirmed he kept his scissors in his pocket and demonstrated they had been inside a plastic bag inside his pocket. He stated he cleaned the scissors before he put them into the bag, and	F0880		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laramie Health and Rehabilitation	**503 S 18th St , Laramie, Wyoming, 82070**

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F0880 SS = D	Continued from page 31 confirmed he did not clean them after removing them from his pocket prior to use on the wound dressing. 3. Interview with the DON on 6/3/26 at 4:03 PM revealed the expectation for wound care was that all tools would be cleaned before using. 4. Review of the "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" showed "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications…. e. Before moving from work on a soiled body site to a clean body site on the same patient f. Immediately after glove removal…Clean and reprocess (disinfect or sterilize) reusable medical equipment…prior to use on another patient and when soiled. a. Consult and adhere to manufacturers' instructions for reprocessing…Reusable equipment should also be transported and stored in a manner to prevent contamination when moved between treatment areas. For example, bandage scissors should not be carried in pockets" 5. Review of the facility policy titled "Cleaning and Disinfecting Resident Care Items and Equipment" showed "1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care:…b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin…2. Critical and semi-critical items are sterilized/disinfected in a central processing location and stored appropriately until use."	F0880		07/10/2026