STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 000	INITIAL COMMENTS A complaint investigation survey was conducted at the facility 5/23/16 through 5/27/16. At the time of the survey the facility census was sixty seven and the sample was fifteen. The survey identified Immediate Jeopardy related to W149, " The facility must develop and implement written policie4s and procedures that prohibit mistreatment, neglect or abuse of the client " . The facility was informed of this Immediate Jeopardy situation on 5/26/16 at 3:05 PM. The facility was asked for a plan to remove the Immediate Jeopardy situation and provided an acceptable plan on 5/27/16 at 12:30 PM.	W 000	**W-104** The governing body must exercise general policy, budget, and operating direction over the facility. The Wyoming Department of Health, Behavioral Health Division has contracted with a national consulting firm beginning June 13, 2016 to provide a highly qualified and experienced Interim Superintendent to provide consistent leadership and management to maintain a stable work environment. Responsible Person(s): Wyoming Department of Health, Behavioral Health Division, Senior Administrator	6/13/16
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility ' s Governing Body failed to provide consistent leadership to maintain a stable work environment, affecting all sixty seven clients at the facility. Findings include: During observations in a facility day program building on 5/23/16 at 10:30 AM, a listing of Superintendents was posted on a bulletin board. This list indicated there had been four Superintendents since 1/10/15 to present. Interim Superintendents worked from 1/10/15 to 4/20/15 and 2/6/16 to 5/18/16. One Superintendent was hired from 4/20/15 to 2/6/16. The current Interim Superintendent was only working part time,	W 104	The Superintendent will provide the oversight, monitoring and review of QAPI reports, revision of policies, ensure necessary staffing, resources, equipment, and training resources. Responsible Person(s): Superintendent, Behavioral Health Division, Senior Administrator A Quarterly Oversight Committee, chaired by the BHD Senior Administrator, has been developed to provide monitoring and compliance of all policies and procedures to ensure adequate staffing, resources, and equipment is available to provide individuals with active treatment and to promote their health and safety. The Oversight Committee began the week of June 3, 2016 while the BHD Senior Administrator was on campus. As part of the Senior Administrator's review were	6/13/16

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

Interim Superintendent / Corrected

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 104	Continued From page 1 dividing his time between the facility and a state psychiatric hospital in another town. This Interim Superintendent started on 5/18/16 and has since announced his retirement the end of June, 2016. During staff interviews starting on 5/23/16 and throughout the survey, staff said the turnover in leadership was difficult and had resulted in unclear guidance and direction for the facility.	W 104	**W-104 Continued** requested scheduled meetings with 25 staff, inspections conducted of all client care areas and input from staff from all areas of operations and client homes, all 7 days, and all shifts. This Senior Administrator reviewed critical policies, worked with the Facility Administrator, members of the Administrative Team, and met with the Guardians. Responsible Person(s): Wyoming Department of Health, Behavioral Health Division, Senior Administrator	6/3/16-6/10/16
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation for Client Protections is not met as evidenced by: Based on interviews and record verification the facility failed to ensure appropriate systems were in place to prohibit abuse, neglect, mistreatment and exploitation of clients in the facility. 1. Immediate Jeopardy was called for neglect on 5/26/16 at 3:05 PM for the facility ' s failure: to develop and implement policy addressing essential requirements for providing 1:1 supervision; to provide a system with clear notifications to ancillary staff members in the event of emergent life threatening situations; ensure an updated program plan for one client was developed that included assessment and interventions related to all current and serious target behaviors. (See W149) 2. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing further potential abuse during investigations, taking and validating appropriate	W 122	Continued recruitment for a qualified permanent Superintendent is ongoing. Responsible Person(s): Wyoming Department of Health, Behavioral Health Division, Senior Administrator Wyoming Department of Health, Behavioral Health Division, Senior Administrator will revisit the facility June 27-28, 2016 to evaluate the progress of the Plan of Correction, observe client care areas and meet with staff as requested. The Senior Administrator will continue to preside over the Quarterly Oversight Committee. Responsible Person(s): Wyoming Department of Health, Behavioral Health Division, Senior Administrator	6/03/16 6/27/16-6/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 104	Continued From page 1 dividing his time between the facility and a state psychiatric hospital in another town. This Interim Superintendent started on 5/18/16 and has since announced his retirement the end of June, 2016. During staff interviews starting on 5/23/16 and throughout the survey, staff said the turnover in leadership was difficult and had resulted in unclear guidance and direction for the facility.	W 104	**W-122** The facility must ensure that specific client protections requirements are met. (See W149, W153, W154, W155, W157). Clients #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation for Client Protections is not met as evidenced by: Based on interviews and record verification the facility failed to ensure appropriate systems were in place to prohibit abuse, neglect, mistreatment and exploitation of clients in the facility. 1. Immediate Jeopardy was called for neglect on 5/26/16 at 3:05 PM for the facility ' s failure: to develop and implement policy addressing essential requirements for providing 1:1 supervision; to provide a system with clear notifications to ancillary staff members in the event of emergent life threatening situations; ensure an updated program plan for one client was developed that included assessment and interventions related to all current and serious target behaviors. (See W149) 2. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing further potential abuse during investigations, taking and validating appropriate	W 122	Process that looks at and reviews all critical policies and considering any modifications to the following policies: 1:1 Staffing policy, Behavioral Safety Response Team (BSRT) policy and Abuse/Neglect policy. Responsible Person: Superintendent A policy has been developed and implemented to address essential requirements for providing 1:1 staff supervision. This policy provides detailed instructions to ensure an individualized program plan is identified for each client receiving 1:1 supervision. All staff have been trained on the policy and on-going competency based monitoring is occurring to ensure staff compliance and client safety. Responsible Person(s): Superintendent, Program Managers A policy has been developed to institute a Behavioral Safety Team Response (BSRT) to ensure a highly effective, consistent and rapid response to behavioral emergencies on campus. The policy identifies roles and responsibilities in assigning staff every shift to ensure adequate numbers of responders are available in the event of emergent life	6/21/16 6/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 104	Continued From page 1 dividing his time between the facility and a state psychiatric hospital in another town. This Interim Superintendent started on 5/18/16 and has since announced his retirement the end of June, 2016. During staff interviews starting on 5/23/16 and throughout the survey, staff said the turnover in leadership was difficult and had resulted in unclear guidance and direction for the facility.	W 104	**W-122 Continued** threatening situations. Practice drills and mock codes for the behavioral safety response team began on June 10, 2016 to evaluate the effectiveness and efficiency of the team process. All staff have been trained on the BSRT policy. All incidents where the BSRT has been initiated will be debriefed by the Administrative Team.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation for Client Protections is not met as evidenced by: Based on interviews and record verification the facility failed to ensure appropriate systems were in place to prohibit abuse, neglect, mistreatment and exploitation of clients in the facility. 1. Immediate Jeopardy was called for neglect on 5/26/16 at 3:05 PM for the facility ' s failure: to develop and implement policy addressing essential requirements for providing 1:1 supervision; to provide a system with clear notifications to ancillary staff members in the event of emergent life threatening situations; ensure an updated program plan for one client was developed that included assessment and interventions related to all current and serious target behaviors. (See W149) 2. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing further potential abuse during investigations, taking and validating appropriate	W 122	Responsible Person(s): Operations Manager The Abuse Neglect Policy has been revised to ensure individuals are free from abuse, neglect, mistreatment and exploitation. All staff have been retrained on this policy with ongoing competency based monitoring. Policy will be distributed to Protection and Advocacy, Inc., WLRC Guardians, and Human Rights Committee members. Responsible Person(s): Administrative Team The revised Abuse and Neglect policy ensures immediate reporting of all suspected abuse and neglect, thorough and immediate investigations to prevent further potential abuse during the investigations and ensuring appropriate corrective actions if violations were verified. Responsible Person(s): Superintendent To provide adequate staffing for timely and through investigations, a second client right specialist position was approved on	6/17/16 6/15/16 6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 104	Continued From page 1 dividing his time between the facility and a state psychiatric hospital in another town. This Interim Superintendent started on 5/18/16 and has since announced his retirement the end of June, 2016. During staff interviews starting on 5/23/16 and throughout the survey, staff said the turnover in leadership was difficult and had resulted in unclear guidance and direction for the facility.	W 104	**W-122 Continued** June 4, 2016 by the Senior Administrator for BHD. Upon approval to fill this position by the State Human Resource Department, active recruitment will begin. Additional administrative support will be provided to both investigators to assist in processing the investigations. Responsible Person(s): Human Resource Manager	7/1/16
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation for Client Protections is not met as evidenced by: Based on interviews and record verification the facility failed to ensure appropriate systems were in place to prohibit abuse, neglect, mistreatment and exploitation of clients in the facility. 1. Immediate Jeopardy was called for neglect on 5/26/16 at 3:05 PM for the facility ' s failure: to develop and implement policy addressing essential requirements for providing 1:1 supervision; to provide a system with clear notifications to ancillary staff members in the event of emergent life threatening situations; ensure an updated program plan for one client was developed that included assessment and interventions related to all current and serious target behaviors. (See W149) 2. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing further potential abuse during investigations, taking and validating appropriate	W 122	The current client rights position duties have been changed to allow for timely and through investigations to be completed. Responsible Person(s): Superintendent A national firm that provides intensive training in investigations and system wide review of policies and training has been contacted. Training will be scheduled in August and completed by August 31, 2016. Responsible Person(s): Human Resource Manager An agenda was developed to be utilized for all Shift Change Meetings to include a reminder to staff to immediately report any suspected abuse or neglect. All Area Unit Supervisors and Shift Supervisors will be trained on the use of this agenda. The agenda will be used at all Shift Change Meetings. Responsible Person(s): Program Managers	6/13/16 August 2016 6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 104	Continued From page 1 dividing his time between the facility and a state psychiatric hospital in another town. This Interim Superintendent started on 5/18/16 and has since announced his retirement the end of June, 2016. During staff interviews starting on 5/23/16 and throughout the survey, staff said the turnover in leadership was difficult and had resulted in unclear guidance and direction for the facility.	W 104	**W-122 Continued** Implement *Don't Wait, Tomorrow is Too Late*! Campaign and cards were distributed to staff beginning June 10, 2016. Responsible Person(s): Program Managers	6/17/16
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The Condition of Participation for Client Protections is not met as evidenced by: Based on interviews and record verification the facility failed to ensure appropriate systems were in place to prohibit abuse, neglect, mistreatment and exploitation of clients in the facility. 1. Immediate Jeopardy was called for neglect on 5/26/16 at 3:05 PM for the facility ' s failure: to develop and implement policy addressing essential requirements for providing 1:1 supervision; to provide a system with clear notifications to ancillary staff members in the event of emergent life threatening situations; ensure an updated program plan for one client was developed that included assessment and interventions related to all current and serious target behaviors. (See W149) 2. The facility failed to implement systems for immediately reporting, thoroughly investigating, preventing further potential abuse during investigations, taking and validating appropriate	W 122	Revise the Walk-A-About (facility wide rounds) checklist and retrain identified staff to include monitoring and interview with 1:1 staff to ensure that the Behavior Support Plan is being fully implemented. The results of the Walk-A-About will be reviewed in the QAPI meetings quarterly. Walk-A-About members will immediately offer technical assistance to address any issue found. Responsible Person(s): QAPI Manager The Facility will increase the frequency of the Policy Review Committee to twice a month, next meeting is June 21, 2016. Direct care staff will be added as members to provide additional input. Responsible Person(s): Superintendent	6/17/16 6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 122	Continued From page 2 corrective action if violations were verified. (See W149, W153, W154, W155, W157)	W 122	**W-149** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Client #5. The Abuse Neglect Policy has been revised to ensure individuals are free from abuse, neglect, mistreatment and exploitation. All staff have been retrained on this policy with ongoing competency based monitoring. Policy will be distributed to Protection and Advocacy, Inc., WLRC Guardians, and Human Rights Committee members. Responsible Person(s): Administrative Team	6/15/16
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to: develop and implement policy with respect to the provision of one to one supervision; implement its system for reporting all allegations; ensure its investigations into allegations were thorough; ensure protection from potential harm during the course of its investigations was provided; corrective action had been completed in response to incidents to prevent future reoccurrence. This potentially affected all clients at the facility. Findings include: On 5/24/16 at 9:20 AM, Client 5 was observed at the facility ' s on-campus day training program working on floor mats. Client 5 who was sitting in a wheelchair during this initial observation demonstrated how he took various colored material to create patterns for the mats. When Client 5 was asked if he got paid for his work, Client 5 responded by saying, " I get paid so poorly I can ' t pay attention. " A Direct Support Professional (DSP) (Tim Johnson) was in the same room with Client 5. Per concurrent interview with the DSP it was revealed Client 5 was on one to one supervision and had been on such for about two years. The DSP stated Client 5 only used a wheelchair for long distances and could ambulate. At the time of interview the DSP was	W 149	The revised Abuse and Neglect policy ensures immediate reporting of all suspected abuse and neglect, thorough and immediate investigations to prevent further potential abuse during the investigations and ensuring appropriate corrective actions if violations were verified. Responsible Person(s): Superintendent A policy has been developed and implemented to address essential requirements for providing 1:1 staff supervision. This policy provides detailed instructions to ensure an individualized program plan is identified for each client receiving 1:1 supervision. All staff have been trained on the policy and on-going competency based monitoring is occurring to ensure staff compliance and	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 3 standing approximately five feet from Client 5. Per review of the facility ' s Wyoming Life Resource Center (WLRC) General Event Report (GER) on 5/26/16 commencing at 8:30 AM it was documented on 5/22/16 shortly after 6:00 PM, Client 5 was observed riding a three wheel bicycle on Chittim Road adjacent to the facility heading towards Highway 789. A staff member was also riding a bike following Client 5, but Client 5 continued to make his way toward the highway which had a posted speed of seventy MPH. The facility ' s Maintenance Supervisor and Security Officer used their vehicles and emergency flashers to alert and slow traffic around Client 5. Client 5 tried to ram his bike into the security vehicle. The security vehicle was pulled forward and off the road. Client 5 shouted he was going to kill himself and then proceeded to move his bike into an on-coming traffic lane, speeding up toward an approaching semi. The Security Officer grabbed the handlebars of Client 5 ' s bike and turned it toward the edge of the road. The bike overturned. The Security officer and Client 5 hit the ground and Client 5 hit the left side of his head on the curb. The Security officer and Client 5 walked back to Client 5 ' s apartment where he continued to threaten staff, clients and his own life until 9:00 PM. Per eyewitness report provided by the Client Rights Advocate (CRA) it was documented the CRA pulled over on Highway 789 and turned on his hazard lights. He described the scene as Client 5 " going clear across the highway into the northbound lane, in front of an on-coming semi - truck. " Per eyewitness report provided by the Maintenance Supervisor (MS) it was documented the MS noticed two bicycles headed down Chittim Road toward Highway 789. The MS wrote, " I	W 149	**W-149 Continued** client safety. Responsible Person(s): Superintendent, Program Managers A Client Abuse/Neglect Investigation policy has been established to provide uniform policy and procedures for investigating abuse/neglect allegations. All investigators and Human Resource staff will be trained by August 31, 2016. Responsible Person(s): Human Resource Manager WLRC will through incident review and the QAPI process identify potential systemic abuse and neglect. Safety Committee will report to QAPI Committee. Safety Committee meeting scheduled for June 22, 2016. Responsible Person(s): QAPI Manager An agenda was developed to be utilized for all Shift Change Meetings to include a reminder to staff to immediately report any suspected abuse or neglect. All Area Unit Supervisors and Shift Supervisors will be trained on the use of this agenda. Responsible Person(s): Program Managers Administrator On-Call will make rounds at least one time during each weekend to provide ongoing monitoring of the 1:1 supervision policy. Responsible Person(s): Administrative On-Call Team	6/13/16 6/17/16 6/22/16 6/17/16 6/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 4 watched as they dipped out of sight thinking surely that if it had been a client, whoever the staff was that was with them would stop them before they reached the highway. But what I saw was alarming. I saw (who later was identified as Client 5) shoot across the highway on the trike. He was not being immediately followed by anyone and at that time I called security. " The MS opined Client 5 " does not possess the coordination skills to outmaneuver staff off this campus. Almost anyone could have caught him and stopped him from entering the highway, either by grabbing the baskets on the back of the bike and grabbing the handle bars. Perhaps however, for the sake of client and staff safety, any and all measures should be taken to insure that no client ever reaches the main highway, I think it is imperative that everyone on campus knows that if they witness a client attempting to leave the property they stop them by whatever means necessary for the clients own safety. " The employee responsible for Client 5 was a shift supervisor who worked voluntary overtime on his day off to accommodate not having enough staff. He was interviewed on 5/26/15 at 10:15 AM. It was revealed during this interview Client 5 was on 1:1 supervision and lived in an apartment by himself. During the day on 5/22/16, Client 5 was taken out in the community for an excursion. The SS explained Client 5 was put in the van near Home 401. The SS had to leave Client 5 alone in the van for a brief time while he retrieved the key which was kept in 401. The SS revealed Client 5 was not allowed to enter other residences due to his past history of aggression. The SS drove Client 5 by himself in the van to get Client 5 ' s soda refilled. At 11:45 AM, the SS had to leave the apartment to enter Home 402 to obtain Client 5 ' s lunch. For	W 149	**W-149 Continued** The revisions in the Abuse Neglect Policy will ensure that all staff alleged for abuse neglect are placed on Administrative Review Leave pending the completed investigation. The Area Unit Supervisor and Program Managers will monitor for violations of this policy. Changes in Abuse and Neglect policy address this issue. Responsible Person(s); Human Resource Manager All Behavior Support Plans for clients currently identified requiring 1:1 supervision to clearly identify 1:1 responsibilities. Responsible Person(s): Program Managers Review all Behavior Support Plans (including 1:1) to determine staffing needs. Monitoring will include leisure time, meal time and morning routines. Responsible Person(s): Program Managers	6/13/16 6/17/16 6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 5 about a minute, Client 5 was again without one to one supervision. When the SS was asked if one to one supervision was provided during the retrieval of keys to the van, or when he obtained the lunch tray for Client 5 from the adjoining residence, the SS remarked, " No. " Client 5 asked the SS if they could go out into the community again to which the SS agreed. This time the SS and Client 5 stopped at the employee ' s home so the SS could obtain some money. For another brief time, Client 5 was left alone in the van while the SS obtained his money. When Client 5 and the SS returned to the facility the SS parked the van by 401 and left Client 5 in the van while he returned the keys. A second shift employee was assigned to work with Client 5, but Client 5 became agitated claiming he did not want to work with that staff member. The SS volunteered to switch assignments and continued working overtime with Client 5. The SS rec ' d a personal phone call at 5:50 PM where he stepped outside of the apartment to take the call. The SS retrieved his phone during the interview and stated the call lasted 1 minute and 42 seconds. At 6:05 PM, Client 5 became more agitated threatening to harm himself and others, including killing all the clients in Home 402. He got on his tricycle and proceeded to ride away from the residence. The SS followed him on bike and verified the drive onto Chittim Road and the subsequent entrance onto Highway 789. The SS conveyed Client 5 crossed the highway on his bike without looking. When the SS was asked if he had tried to intervene with Client 5 before Client 5 made it to the highway, the SS explained he was not sure what to do because he had never encountered a situation like that and he was concerned about	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 6 the type of techniques that could be used. The SS explained there were no specific procedures outlined for Client 5 should an elopement occur. Per interview with Client 5 ' s Behavior Specialist (BS) on 5/26/16 at 11:30 AM with Client 5 ' s Behavior Support Plan (BSP) available for review, the BS was asked if the plan identified expectations for 1:1 supervision with respect to the distance staff must maintain when working with him. He was also asked if there were provisions for leaving the assignment even for brief periods of time, or whether or not there had been any consideration about a driver performing 1:1 supervision while driving Client 5 around town. The BS explained the BSP identified things that should be done with Client 5 when he was on 1:1 supervision, but there was no detailed level of specificity with respect to how 1:1 supervision was expected to be maintained in those events queried. When the BS was asked if physical interventions were addressed in the plan outlining techniques that could be used if Client 5 tried to leave the campus, the BS explained an escort procedure could have been used, but it was not specific to the current version of the BSP dated 5/17/16 as elopement was not a target behavior. When asked if Client 5 had any elopement issues the BS explained Client 5 threatened to grab hold of the steering wheel back in January of 2016, but he was not in a vehicle at the time. The BS also identified during the week prior to the event of 5/22/16, Client 5 left the home on foot stating he wanted to leave the facility and never return. Staff members were with him and were able to convince him to return to his apartment, but Client 5 still made it all the way to the front gate which is adjacent to Highway 789. Immediate Jeopardy was called on 5/26/16 at	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 7 3:05 PM for the facility ' s: lack of clear instructions to staff regarding the performance of 1:1 supervision in the areas of obtaining lunch, getting vehicle keys, driving alone in a vehicle with Client 5 and employee breaks; lack of clear notifications to ancillary staff members in the event of emergent life threatening situations; the lack of a program plan update that included assessment and interventions related to all current target behaviors. The facility presented its abatement plan on 5/27/16 which included: development of a comprehensive policy for special observations and procedures providing specific guidelines and expectations for one to one supervision; a Safety Response Team and policy to direct staff in both behavioral and medical emergency safety responses including drills; a revision to Client 5 ' s behavior support plan which included all current target behaviors and associated interventions. Immediate Jeopardy was lifted on 5/27/16 at 12:30 PM. The facility policy titled " Client Rights and Protection " was reviewed upon presentation on 5/23/16. It stated, " The purpose of this policy is to provide guidelines for identifying, reporting and responding to actions, which may be considered abuse, neglect, or rights violations by staff, volunteers, visitors, or others toward a client living at WLRC. Reporting - Under " 9 " it stated, " If an employee witnesses a potential act of abuse/neglect and fails to report it to the proper authority, he/she may be subject to disciplinary action as well as consequences outlined in the Wyoming Adult Protection Services Statute. " Under " Procedure " it stated, " Employees who have witnessed abuse, neglect, or have been told about the abuse or neglect by clients or other	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 8 staff shall immediately make a report to the Superintendent, Administrator on Call or the Client Rights Advocate. " Per review of incidents identified on the facility ' s Abuse/Neglect/Rights Referral Reports generated between March 21st, 2016 and May 18th, 2016 it was determined ten of thirty seven incident reports requiring immediate notification to the facility director were deemed late. Per interview with the Client Rights Advocate (CRA) on 5/27/16 commencing at 9:25 AM the CRA was asked to comment on the number of late reports identified since March 21st, 2016. The CRA opined reporting was a longstanding " systemic issue. " He articulated brand new people have a fear to report and experienced staff turn the other way until guilt sets in. The CRA also identified some of his training initiatives where he has spoken to various groups about reporting requirements. The CRA further opined evenings and weekends as the times when most late reporting had occurred. To address this problem the CRA also explained the recently instituted Administrator on Call (AOC) system hoping that its initiation would allay the issue of late reporting. Thoroughness -The facility policy was absent of any guidelines addressing how to conduct a thorough investigation. Per review of incidents identified on the facility ' s Abuse/Neglect/Rights Referral Reports dated March 21st, 2016 through May 18th, 2016 it was determined eight of thirty seven incident reports investigated were not thorough. Per interview with the CRA on 5/27/16 commencing at 9:25 AM the CRA explained he has put together a " how to do list " for investigations including pertinent and relevant information, but also acknowledged specific	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 9 pieces on how to conduct a thorough investigation were not identified in policy. Protection during Investigations - With respect to prevention of further potential abuse while an investigation is in process the facility policy stated under B.2.b. - " Immediately temporarily separate an accused staff from clients. " It further stated under 3 - " The Superintendent and Client Rights Advocate will assess the situation for the immediate interventions needed and take appropriate administrative action to prevent further potential abuse while the investigation is in progress. " Per interview with the CRA on 5/27/16 commencing at 9:25 AM the CRA opined the facility has gotten better in this aspect and then offered an explanation regarding the decision to return the staff member potentially negligent in the weekend elopement of Client 5 back to work prior to the completion of the facility investigation. Per the CRA the staff member was not viewed as a threat to clients and was only in contact with clients for three hours when the staff member was allowed to work in Home 401 on 5/26/16. The CRA explained the reason for this decision was related to a staff shortage that morning. Corrective Action - The facility policy does not address where corrective action is to be maintained. Per review of incidents identified on the facility ' s Abuse/Neglect/Rights Referral Reports dated March 21st, 2016 through May 18th, 2016 it was determined the status of corrective action in response to two incident reports with recommendations was not identifiable. Per interview with the CRA on 5/27/16 commencing at 9:25 AM the CRA admitted he does not do any follow-up on proposed or completed corrective action taken in response to	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 149	Continued From page 10 incidents. He explained such action was most likely kept at the Program Manager level.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and incident review the facility failed to ensure all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown source were immediately reported to the Facility Administrator. This affected ten of thirty seven incidents reported during the time parameter of 3/21/16 and 5/22/16 and nine clients, Clients 2, 3, 4, 9, 10, 11, 12, 13 and 14. Findings include: During review of incidents on 5/25/16 commencing at 8:55 AM for incidents documented on the facility ' s " Summary of Abuse/Rights Referral Reports " generated during the time parameter 3/21/16 through 5/22/16 the following incidents were identified as not being immediately reported to the Facility Director. On 3/28/16 at 8:45 PM, Client 2 was observed grabbing a piece of cheese from a sack of food in the garbage can and stuffed it into his mouth. Client 2 would not allow staff to perform abdominal thrust on him until Client 2 " passed out. " The report for this event was generated on 3/29/16. Per interview with the Client Rights Advocate (CRA)/Investigator on 5/25/16 at 10:35	W 153	**W-153** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Clients#2, #3, #4, #9, #10, #11, #12, #13, #14. The mechanisms being put in place to ensure rapid detection, reporting and rigorous follow-up include: The Abuse Neglect Policy has been revised to ensure individuals are free from abuse, neglect, mistreatment and exploitation. All staff have been retrained on this policy with ongoing competency based monitoring. Policy will be distributed to Protection and Advocacy, Inc., WLRC Guardians, and Human Rights Committee members. Responsible Person(s): Administrative Team The revised Abuse and Neglect policy ensures immediate reporting of all suspected abuse and neglect, thorough and immediate investigations to prevent further potential abuse during the investigations and ensuring appropriate corrective actions if violations were verified. Responsible Person(s): Superintendent	6/15/16 6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 153	Continued From page 11 AM the CRA confirmed the report was late. On 3/30/16 a General Event Report (GER) documented Client 3 was discovered with a bruise on second shift the day before on 3/29/16. The client sustained a quarter sized bruise on the left bicep suspected as finger prints and was further described as possibly being three to four days old. Per interview with the CRA/Investigator on 5/25/16 at 10:35 AM the CRA confirmed the report was late as the actual date of original injury was unknown. On 4/3/16 a note was written alleging a Direct Support Professional (DSP) who was assigned one to one supervision was found asleep several times on the night shift and was not providing visual observation to Client 9. The note intimated the Shift Supervisor (SS) also allowed the DSP to continue to work the one to one assignment until the employee was finally relieved of duty at 3:00 AM. Per interview with the CRA/Investigator not only was the report late, no required incident report had been completed for the event until 4/5/16. On 4/4/16 an allegation of mistreatment was made at 8:00 AM for Client 10 indicating a Medication Aide was combative towards Client 10 demanding Client 10 leave Home 402. The incident allegedly took place the day before on 4/3/16 at 4:00 PM. Per interview with the CRA/Investigator on 5/25/16 at 10:35 AM the CRA confirmed the report was late. On 4/14/16 an incident report was generated alleging a choking incident had occurred six days earlier on 4/8/16 wherein Client 2 got behind the kitchen counter and got a hold of a hot dog. Attempts were made to clear Client 2 ' s throat and attempts to perform the abdominal thrust were initially unsuccessful. The incident further documented a DSP who was performing one to	W 153	**W-153 Continued** The Abuse Neglect Policy ensures that staff report allegations of abuse, neglect or rights violations by staff, volunteers, visitors or others. Responsible Person(s): Program Managers Implement *Don't Wait, Tomorrow is Too Late*! Campaign and cards were distributed to staff starting on June 10, 2016. Responsible Person(s): Program Managers An agenda will be developed and adhered to for Shift Change Meetings including a reminder to staff to immediately report any suspected abuse or neglect. Train staff. Responsible Person(s): Program Managers	6/17/16 6/17/16 6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 153	Continued From page 12 one supervision at the time with another client turned his back on the staff member who asked for his assistance. Per interview with the CRA/Investigator on 5/25/16 at 10:35 AM the CRA confirmed the report was late. On 4/18/16 at 7:20 AM an allegation of mistreatment was reported on behalf of Client 11 alleging an employee told Client 11 to stop acting like another Client. The allegation also stated the employee screamed at Client 11. Per interview with the CRA/Investigator on 5/26/16 at 10:35 AM he stated he was not aware of the allegation until 4/20/16 and the reporter allegedly left out crucial information which turned out to be the crux of the investigation identifying the reporter as the alleged perpetrator. On 4/18/16 an incident report was generated for potential mistreatment of Client 12 that had occurred during the week of 4/10/16 through 4/18/16 by Client 12 ' s mother. It was documented Client 12 ' s mother was on a week ' s long visit and was observed cussing at her son, calling him derogatory names and making threats to spank him along with other inappropriate statements and actions. Staff statements were obtained on 4/18/16 and all witnesses alleged the events took place across several days during the week of 4/10/16. In an interview with the CRA/Investigator on 5/25/16 at 2:40 PM the CRA confirmed the report was late. During review of incidents on 5/25/16 at 10:30 AM it was determined an incident reported on 5/7/16 involving Client 4, wherein Client 4 was given a pill that had fallen on the floor was not reported until 5/8/16. When interviewed on 5/25/16 at 10:30 AM the CRA confirmed that the incident had been reported late.	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 153	Continued From page 13 On 5/10/16 a concern was raised by an employee alleging a DSP might be giving Client 13 food and liquids " outside of his care plan. " The report on 5/11/16 documented Client 13 was allegedly told he could eat popcorn and lick the bag at the movies. " On 5/25/16 at 2:40 PM when the CRA/Investigator was asked if this was a late report, the CRA responded, " Absolutely. " On 5/10/16 at 8:20 PM, it was documented per incident report a DSP found another DSP with a cell phone in his hands while Client 14 was naked on the toilet. The witnessing DSP claimed the responsible DSP quickly hid his phone in his pocket. The incident was reported as potential sexual exploitation. The document had additional information stating, " The Administrator on Call (AOC) does not appear to have been called by the reporter. The report was written out and dropped in the security box, but not received until 5/12/16. " Per interview with the CRA on 5/25/16 at 2:40 PM, this was considered a late report. Even though it was written at the time of occurrence verbal notification to the AOC had not occurred until two days later.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and incident review the facility failed to ensure its investigations into allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown source were thoroughly investigated for those reported during the time parameter of 3/21/16 through 5/18/16.	W 154	**W-154** The facility must have evidence that all alleged violations are thoroughly investigated. Clients #2, #3, #9, #12, #13, #15. The Director of Nursing will conduct a debriefing of all choking events to include therapy staff, direct support staff involved in the incident and others as needed. The debriefing will review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 154	Continued From page 14 This affected seven of thirty seven incidents reported and six clients at the facility, Clients 2, 3 9, 12, 13 and 15. Findings include: During review of incidents on 5/25/16 commencing at 8:55 AM for incidents documented on the facility ' s " Summary of Abuse/Rights Referral Reports " generated during the time parameter 3/21/16 through 5/18/16 the following incidents were identified as not being thoroughly investigated. On 3/28/16 at 8:45 PM, Client 2 observed with his " cheeks full " and began to choke. A Med Aide started abdominal thrusts but was unsuccessful as Client 2 fought her. A second Direct Support Professional (DSP) came to assist and initiated CPR. Security also arrived and attempted abdominal thrusts and on the fifth attempt, Client 2 " started breathing. " EMS arrived for further assistance. Per interview with the Client Rights Advocate/Investigator (CRA) on 5/25/16 commencing at 10:35 AM the CRA was asked if staff statements had been obtained detailing their performance in applying the abdominal thrusts, if any photos had been taken of the area, if any diagrams had been made, or if there had been any analysis of the EMS response system. The CRA explained that none of that had been done. The CRA did identify a plan of corrective action to empty the garbage can after meals but when questioned about that specific action, it was revealed it had actually been a recommendation prior to the event. When asked if this had been investigated as potential neglect the CRA stated it had not. On 3/30/16 a GER documented Client 3 was discovered with a bruise on second shift the day before on 3/29/16. A quarter sized bruise was	W 154	**W-154 Continued** first aid procedures administered as well as an environmental assessment. A written analysis and recommendations will be submitted to the team within 3 days. Director of Nursing will develop a tool to be completed during the debriefing. Responsible Person(s): Director of Nursing All choking incidents are reviewed by the Nutritional Risk Committee monthly. They will also be reviewed during QAPI Committee meeting. Responsible Person(s): QAPI Manager, Director of Nursing	6/17/16 6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 154	Continued From page 15 observed on the left bicep suspected as " finger prints " and was further described as possibly being three to four days old. Per interview with the CRA/Investigator on 5/25/16 at 10:35 AM the CRA was asked if a time line had been constructed to determine how Client 3 was ambulated and by whom, since Client 3 was on one to one supervision for ambulation during the three to four days identified. The CRA stated no statements were available in his file, but they may have been obtained by the Program Manager. On 4/3/16 a note was written alleging a Direct Support Professional (DSP) who was assigned one to one supervision with Client 9 was found asleep several times on the night shift and was not providing visual observation. The note intimated the Shift Supervisor also allowed the DSP to continue to work the one to one assignment until the employee was finally relieved of duty at 3:00 AM. Per interview with the CRA/Investigator no incident report had been completed for this event. When the CRA was asked if the facility had investigated this matter as potential neglect on the part of the SS for allowing the employee to continue to work the one to one supervision assignment even though the employee had been caught sleeping by the SS several times during the shift, the CRA/Investigator stated that the incident had not been investigated from that aspect. On 4/14/16 an incident report was generated alleging a choking incident had occurred six days earlier on 4/8/16 wherein Client 2 got behind the kitchen counter and got a hold of a hot dog. Attempts were made to clear Client 2 ' s throat, but attempts at the abdominal thrust were initially unsuccessful. The incident further documented a	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 154	Continued From page 16 DSP who was performing one to one supervision at the time with another client turned his back on the staff member who asked for assistance. When the CRA was asked if the investigation addressed the issue why employees had difficulty performing abdominal thrusts with Client 2 since this was the second choking incident within a month, or if Client 2 ' s history of choking had been reviewed the CRA explained those details were not explored or investigated. On 4/15/16 Client 15 who was on one to one supervision was found in the morning with a pen in his rectum. Feces and sperm were also discovered in Client 15 ' s bed. In an interview with the CRA on 5/25/6 at 11:55 AM the CRA revealed this investigation had been conducted by the Area Unit Supervisor (AUS). When the CRA was asked if documentation of searches as outlined in Client 15 ' s behavior plan had been reviewed, the CRA explained there was no evidence searches had been done as far as he could determine. On 4/18/16 an incident report was generated for potential mistreatment of Client 12 that occurred during the week of 4/10/16, allegedly by Client 12 ' s mother. It was documented Client 12 ' s mother was on a week ' s long visit and was observed cussing at her son, calling him derogatory names and making threats to spank him along with other inappropriate statements and actions. Staff statements were obtained on 4/18/16 and all witnesses alleged the events took place across several days during the week of 4/10/16. In an interview with the CRA on 5/25/16 at 2:40 PM the CRA was asked if the investigation determined the exact number of times Client 12 ' s mother visited during the week of 4/10/16 and how many times she mistreated her son. The	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 154	Continued From page 17 CRA confirmed the depth of the investigation did not go into that level of detail. On 5/10/16 a concern was raised by an employee alleging a DSP might be giving Client 13 food and liquids " outside of his care plan. " The report on 5/11/16 documented Client 13 was allegedly told he could eat popcorn and lick the bag at the movies. " On 5/25/16 at 2:40 PM when the CRA was asked if all the potential witnesses had been identified who may have been privy to the event had been interviewed and whether a determination been made as to whether or not Client 13 actually received any of the items alleged to be outside the guidelines of his plan, the CRA explained those questions had not been asked or answered.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and incident review the facility failed to ensure client protection was afforded during one allegation of potential sexual exploitation and one allegation of neglect. This affected two clients, Clients 5 and 14. Findings include: During review of incidents on 5/25/16 commencing at 8:55 AM it was revealed an incident report was completed on 5/10/16 at 8:20 PM, wherein it was documented a Direct Support Professional (DSP) found another DSP with a cell phone in his hands while Client 14 was sitting naked on the toilet. The witnessing DSP claimed the responsible DSP quickly hid his phone in his pocket. The actions were viewed as suspicious	W 155	**W-155** The facility must prevent further potential abuse while the investigation is in progress. Clients #5, #14. The mechanisms being put in place to ensure rapid detection, reporting and rigorous follow-up include: The Abuse Neglect Policy has been revised to ensure individuals are free from abuse, neglect, mistreatment and exploitation. All staff have been retrained on this policy with ongoing competency based monitoring. Policy will be distributed to Protection and Advocacy, Inc., WLRC Guardians, and Human Rights Committee members. Responsible Person(s): Administrative Team The revised Abuse and Neglect policy ensures immediate reporting of all suspected abuse and neglect, thorough and immediate investigations to prevent further potential abuse during the investigations and ensuring appropriate corrective actions if violations were	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 155	Continued From page 18 and the incident was reported as potential sexual exploitation. Per interview with the CRA/Investigator (CRA) on 5/25/16 at 2:40 PM to determine what client protection measures were immediately put into place when the allegation was first made, the CRA revealed the case was still open as it was reported to the local police. With respect to the facility investigation, the alleged perpetrator had two consecutive days off on 5/11/16 and 5/12/16 and was placed out on administrative leave pending the results of the police investigation. Since the incident occurred on 5/10/16 at 8:45 PM, the CRA was asked if there was any evidence the employee had been immediately removed from contact with clients the night of the incident. The CRA/Investigator could not verify if that had occurred opining documentation in the report indicated it had taken place on 5/11/16. Review of the facility ' s Wyoming Life Resource Center (WLRC) General Event Report (GER) on 5/26/16 commencing at 8:30 AM revealed on 5/22/16 shortly after 6:00 PM, Client 5 was observed riding a three wheel bicycle on Chittim Road adjacent to the facility heading towards Highway 789. A staff member was also riding a bike following Client 5, but Client 5 continued to make his way toward the highway which had a posted speed of seventy MPH. The facility ' s Maintenance Supervisor and Security Officer used their vehicles and emergency flashers to alert and slow traffic around Client 5. Client 5 tried to ram his bike into the security vehicle. The security vehicle was pulled forward and off the road. Client 5 shouted he was going to kill himself and then proceeded to move his bike into an on-coming traffic lane, speeding up toward an approaching semi. The Security Officer grabbed the handlebars of Client 5 ' s bike and turned it	W 155	**W-155 Continued** verified. Responsible Person(s): Superintendent The Abuse Neglect Policy ensures that staff report allegations of abuse, neglect or rights violations by staff, volunteers, visitors or others. Responsible Person(s): Program Managers Implement *Don't Wait, Tomorrow is Too Late*! Campaign and cards were distributed to staff starting on June 10, 2016. Responsible Person(s): Program Managers The Client Rights Specialist will maintain a database identifying all allegations of abuse/neglect. These reports will be reviewed in the Quarterly Oversight Committee. The Superintendent will review twice weekly. Responsible Person(s): Client Rights Specialist	6/15/16 6/17/16 6/17/16 6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 155	Continued From page 19 toward the edge of the road. The bike overturned. Security staff and Client 5 hit the ground and Client 5 hit the left side of his head on the curb. The Security Officer and Client 5 walked back to Client 5 ' s apartment where he continued to threaten staff, clients and his own life until 9:00 PM. Per interview with the responsible employee on 5/26/16 at 10:15 AM to discuss his assignment since the incident, the DSP explained he went off duty on 5/22/16 since he had been on overtime and had three days off. The DSP explained he was brought back to work on 5/26/15 with the stipulation he could work with other clients in Home 401, but not Client 5. In a follow-up interview with the CRA/Investigator on 5/27/16 to verify the employee ' s work assignment, the CRA/Investigator explained the facility was short of staff and keeping him away just from Client 5 was appropriate for the situation.	W 155		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview and incident review the facility failed to ensure corrective action was completed in response to allegations of abuse, neglect, mistreatment and exploitation. This occurred for two of thirty seven incidents reported during the time parameter of 3/21/16 through 5/18/16 and affected two clients at the facility, Clients 2 and 12. Findings include: During review of incidents reported by the facility on 5/25/16 commencing at 8:55 AM for those	W 157	**W-157** If the alleged violation is verified, appropriate corrective action must be taken. Clients #2, #12. The Abuse Neglect Policy has been revised to ensure individuals are free from abuse, neglect, mistreatment and exploitation. All staff have been retrained on this policy with ongoing competency based monitoring. Policy will be distributed to Protection and Advocacy, Inc., WLRC Guardians, and Human Rights Committee members. Responsible Person(s): Administrative Team	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 157	Continued From page 20 reported between 3/21/16 and 5/18/16 the following incidents were identified as not having corrective action considered or documented in response to the event. On 3/28/16 at 8:45 PM, Client 2 was observed with his " cheeks full " and began to choke. A Med Aide started abdominal thrusts but was unsuccessful as Client 2 fought her. A Direct Support Professional (DSP) came to assist and initiated CPR. Security also arrived and attempted abdominal thrusts and on the fifth attempt, Client 2 " started breathing. " EMS arrived for further assistance. On 4/14/16 another incident report was generated alleging a choking incident had occurred six days earlier on 4/8/16 wherein Client 2 got behind the kitchen counter and got a hold of a hot dog. Attempts were made to clear Client 2 ' s throat, but abdominal thrusts were initially unsuccessful. The incident further documented a DSP who was performing one to one supervision at the time with another client turned his back on the staff member who asked for assistance. Subsequent review of the facility ' s database specific to clients and choking incidents revealed Client 2 had two prior choking incidents that occurred on 10/22/15 and 11/22/15. Though environmental considerations had been identified in response to those two sentinel events, neither one identified any need for re-training, nor any consideration for the conduct of emergency drills. Per interview with the Client Rights Advocate/Investigator (CRA) on 5/25/16 commencing at 10:35 AM to ascertain what corrective action had been taken in response to the two most recent choking events, the CRA identified the recommendations that were made at the time of the investigation. When the CRA was asked if the facility conducted any	W 157	**W-157 Continued** The revised Abuse and Neglect policy ensures immediate reporting of all suspected abuse and neglect, thorough and immediate investigations to prevent further potential abuse during the investigations and ensuring appropriate corrective actions if violations were verified. Responsible Person(s): Superintendent The Abuse Neglect Policy ensures that staff report allegations of abuse, neglect or rights violations by staff, volunteers, visitors or others. Responsible Person(s): Program Managers The WLRC will evaluate the seriousness of each violation when the intentional action or inaction action of a staff person has resulted in abuse, neglect or mistreatment which was a serious and immediate threat to the individual's health and safety, appropriate disciplinary action will be taken which may include termination. The corrective action taken should make it reasonably likely to prevent the abuse, neglect mistreatment or injury from reoccurring. Responsible Person(s): Human Resource Manager, Client Rights Specialist	6/17/16 6/17/16 6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 157	Continued From page 21 emergency drills to ensure employee competency in skills commensurate with training, the CRA opined to the best of his knowledge that had not been considered. On 4/18/16 an incident report was generated for potential mistreatment of Client 12 that occurred during the week of 4/10/16, allegedly by Client 12 ' s mother. It was documented Client 12 ' s mother was on a week ' s long visit and was observed cussing at her son, calling him derogatory names and making threats to spank him along with other inappropriate statements and actions. Staff statements were obtained on 4/18/16 and all witnesses alleged the events took place across several days during the week of 4/10/16. Ted from Per interview with the CRA on 5/25/16 at 2:40 PM the CRA was asked what action had been taken in response to Client 12 ' s mother such as: supervised visits; a suspension of visits; development of DSP responses should an event like this reoccur. The CRA explained there were no current restrictions on visits and that Client 12 ' s mother is scheduled for another visit in August 2016. On 5/27/16 the CRA presented copies of emails distributed to several facility employees as evidence of some follow-up on corrective action related to one incident. The e-mails were dated 5/26/16.	W 157	**W-157 Continued** The investigator completes the investigative report within 5 days and sends to the Superintendent and the QAPI Manager within 5 working days. Sufficient staff will be deployed to eliminate the backlog of investigations by July 20, 2016. Corrective action will be assigned to appropriate manager including completion dates. Superintendent and the QAPI Manager will meet weekly to review. QAPI Manager will immediately inform Superintendent when as assigned completion date has not been met. QAPI Manager will forward copies of corrective actions to the investigator for each abuse file. By July 20, 2016 the backlog of investigations will be eliminated. Responsible Person(s): Superintendent and QAPI Manager	7/20/16
W 164	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.	W 164	**W-164** Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Clients #5, #7, #8.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 164	Continued From page 22 This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the professional services of a psychologist to the clients at the facility. This potentially affected all clients at the facility with affective, emotional and behavior management needs. Findings include: During observations in Home 402 on 5/24/16 commencing at 8:00 AM it was revealed three clients were in the home, one client was in an apartment and two clients client had already left the home to begin their work program. The Behavior Support Plan (BSP) for one client who had already left for work Client 7 was reviewed. The primary target behavior for amelioration was self-injurious behavior. It was revealed the author of the BSP was a facility Behavior Specialist who implemented the program on 3/19/14. Revisions to the plan were also evident in the BSP with the most recent revision dated 5/13/16. During observation of Client 5 on 5/24/16 at 9:30 AM in the Hunt day program it was revealed by the Direct Support Professional (DSP) in the work area Client 5 lived in his own apartment but was on 1:1 supervision. At the time of observation the DSP was standing approximately five feet away from Client 5 who was sitting at his work station in a wheelchair. Client 8 was observed in Room 117 of the Emerson Building on 5/24/16 at 10:05 AM. Client 8 was asleep in a chair with a kerchief around his neck. Client 8 was noted with saliva drooling outside of his mouth. Per concurrent discussion with the DSP it was revealed Client 8 slept a lot. When asked if Client 8 had any behavioral issues the DSP explained he puts his hands down his pants. When asked what was done in response	W 164	**W-164 Continued** The WLRC will coordinate with WSH to access consultation from a clinical psychologist on an as needed basis and will continue to recruit for a permanent full-time position. Responsible Person(s): Superintendent The facility is working with a national recruiting firm to recruit a PhD clinical psychologist. Responsible Person(s): Superintendent, Human Resource Manager The facility is working with a national recruiting firm to recruit two QIDPs. Responsible Person(s): Superintendent, Human Resource Manager	6/17/16 6/27/16 6/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 164	Continued From page 23 to that behavior the DSP stated she walked him to the sink and washed his hands. Subsequent review of the Client Profile available in Client 8 ' s program book identified smearing feces on face and pica as a safety concern. No formal program was available for these concerns but " Guidelines " dated 7/8/14 were referenced. Per interview with the Behavior Specialist (BS) for Clients 7 and Client 5 on 5/23/16 commencing at 1:05 PM it was revealed the BS was responsible for developing behavior management programs for the clients observed at Home 402 who attended the Hunt program in addition to the other clients in his caseload. The BS stated he also knew Client 8 from previously working with him and acknowledged Client 8 once had a formal program to address target behaviors related to smearing feces, but that program had since been discontinued. The BS was asked to describe psychological services offered at the facility. The BS relayed that he and another Behavior Specialist were the authors of all behavior programs. No psychologist was available to conduct any psychological evaluations, nor was there anyone available to assist them with complex cases. The BS provided some historical insight into previous staffing from two years ago denoting the facility ' s psychological service program was staffed by a psychologist and three behavior specialists. The BS opined, " We ' re now on our own. " When asked if any consultants were available, the BS reported there was a state consultant but connecting with that person and getting a commitment for assistance was hard to obtain. The BS stated he has reached out on his own to other consultants both locally and nationally, but consultations did not always materialize. Per follow-up interview with the Facility Director	W 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 164	Continued From page 24 (FD) on 5/26/16 at 8:55 PM to determine current plans for recruitment of a psychologist, the FD explained he was trying to recruit one as the facility was planning to open up a specialty program for individuals with dual diagnosis. Per follow-up interview with the Human Resource Director (HRD) on 5/27/16 at 12:20 PM to ascertain the difficulties, if any, to establish a position for a psychologist, the HRD opined it was relatively simple explaining she needed to take a vacant position and reclassify it and then added she would have to find a vacant position with a commensurate salary. When asked how long the whole process took to establish the position the HRD replied about three days.	W 164		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interview and incident review the facility failed to ensure adequate staffing was available prior to two incidents of elopement where clients were temporarily without supervision. This affected two clients in the facility, Clients 5 and 6. Findings include: During review of incident reports on 5/25/16 commencing at 8:55 AM for those generated during the time parameter of 3/21/16 and 5/22/16 it was revealed the facility reported an incident	W 186	**W-186** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Clients #5, #6. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. A policy has been developed to institute a Behavioral Safety Team Response (BSRT) to ensure a highly effective, consistent and rapid response to behavioral emergencies on campus. The policy identifies roles and responsibilities in assigning staff every shift to ensure adequate numbers of responders are available in the event of emergent life threatening situations. Practice drills and mock codes for the behavioral safety response team began on June 10, 2016 to evaluate the effectiveness and efficiency of the team process. All staff have been trained on the Behavioral Safety Team Response Policy. All incidents where the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 186	Continued From page 25 involving Client 6 wherein Client 6 was discovered outside his home on 4/9/16 at 9:30 AM by a facility Registered Nurse (RN). No staff member was with Client 6 at the time and Client 6 had scrapes on all five toes upon nursing assessment. The summary conclusion for this event stated, " The problem in this case is staffing. " On 5/26/16 commencing at 8:30 AM an incident involving Client 5 was reviewed. While on one to one supervision on 5/22/16 Client 5 eluded a staff member on bike and entered Highway 789 in an attempt to kill himself. Per interview with the staff member responsible for Client 5 ' s supervision on 5/26/16 at 10:15 AM it was revealed the employee was a shift supervisor who was called into work the morning of 5/22/16 to perform the one to one direct care staff duties with Client 5 due to a shortage of male staff. The employee also worked overtime on second shift doing direct care duties when the incident occurred because Client 5 did not like the original male staff assigned to work one to one supervision with him. The SS also revealed male staff worked almost exclusively with Client 5 due to his historical inappropriate interactions with females and this often affected the facilities ability to obtain coverage.	W 186	**W-186 Continued** BSRT has been initiated will be debriefed by the Administrative Team. Responsible Person(s): Operations Manager A policy has been developed and implemented to address essential requirements for providing 1:1 staff supervision. This policy provides detailed instructions to ensure an individualized program plan is identified for each client receiving 1:1 supervision. All staff have been trained on the policy and on-going competency based monitoring is occurring to ensure staff compliance and client safety. Responsible Person(s): Superintendent, Program Managers	6/17/16 6/16/16
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 189	**W-189** The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 189	Continued From page 26 failed to provide new employee orientation to one Nurse Practitioner employed at the facility since October, 2015. Findings include: On 5/23/16 at 12:40 PM the facility ' s new employee orientation training (NEO) and staff development in-service courses offered on an annual and bi-annual basis were reviewed. It was determined the facility offered training in the following areas: client rights; safe lifting; infection control; fire safety; serving foods safely; Mandt system; heart saver first aid; heart saver CPR; BLS CPR (specifically for Med Aides, Nursing and Security); airway management for Nursing; medication administration procedures manual (specifically for Med Aides). Per interview with the Senior Human Resource Associate (HRA) on 5/23/16 at 12:45 PM the HRA explained NEO training required two weeks of classroom training and two weeks on the job training in the employee ' s specific area of assignment. A list of NEO cycles was presented for review on 5/23/16 at 4:00 PM and it identified training occurred on: December 7th, 2015; January 4th, 2016; February 8th, 2016; April 4th, 2016 and May 2nd, 2016. Another NEO cycle was also scheduled to occur on June 1st, 2016. During an interview on 5/27/16 at 8:30 AM, the Director of Nursing said that the Nurse Practitioner had not attended NEO at the time of hire and had not completed the training as of the survey exit.	W 189	**W-189 Continued** The Human Resource Department will review the training database to ensure all new employee orientation is current. If a staff is identified as not completing orientation they will attend the new employee orientation which is scheduled monthly. Responsible Person(s): Human Resource Manager The Human Resource Manager will coordinate with Staff Development to develop an abbreviated new employee orientation schedule that would allow for proficiency testing in lieu of attending each class. Responsible Person(s): Human Resource Manager	6/14/16 7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 189	Continued From page 27 The facility presented no additional records to verify the Nurse Practitioner had attended and completed NEO training.	W 189		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure behavior altering medication was not given on a PRN basis. This affected three clients in the sample, Clients 5, 7 and 9. Findings include: The facility ' s Policy titled " Medication " was reviewed on 5/25/16 at 3:30 PM. It had the following subtitle, " Psychoactive Medication Usage and Behavior Medication Review Committee. " Under " Policy " it defined psychoactive medications as those including but not limited to the classes of drugs known as anti-psychotics, anti-anxiety, anti-depressants and sedative/hypnotics, and epileptics when used for behavioral indications. Under " Policy " it stated " 1. For all clients receiving psychoactive medications for behavioral purposes, a Behavior Support Program (BSP) is required " and " 2. WLRC clients have the right to be free from unnecessary or excessive use of psychoactive medications. These medications shall not be used as punishment, for the convenience of staff, as a substitute for programs, or in quantities that interfere with the	W 312	W-312 Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Clients #5, #7, #9. All clients with PRN psychotropic medications were identified and special BMRC (Behavior Management Review Committee meetings will be held with the IDT to develop plan for discontinuation of all PRN psychotropic medications with guardian input. Responsible Person(s): Director of Nursing	7/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 312	Continued From page 28 client ' s habilitation unless medically indicated. " The policy further elaborated the function of the Behavior Management Review Committee (BMRC) and item 7, stated, " PRN orders for psychoactive medications will not be used on a routine basis. PRN orders will only be utilized on an individual basis as part of the BMRC Report with the consent of the BMRC. All PRN orders for psychoactive medications will be reviewed by the BMRC and monthly by the Client Rights Specialist. " Per interview with the facility ' s Pharm D. on 5/25/16 at 3:30 PM the pharmacist was aware of the language in the guidelines regarding prohibition of PRN usage of behavior altering medications and stated the facility had contacted a consultant for an opinion last year in August of 2015. Per the consultant ' s e-mail correspondence received the pharmacist explained the consultant ' s opinion clarified the position and " covered " the facility in their continued use of behavior altering mediations. The pharmacist also opined she had noticed an increase in PRN medication for behavioral intervention since September 2015. A list was provided for all clients who had received behavior altering medication on a PRN basis. Within the time parameter February through April 2016 the following clients received PRNs. Client 7 received PRN Alprazolam 0.5 milligrams 2 tablets on: 2/11/16: 2/12/16; 2/19/16; 2/22/16 and 3/7/16. Per review of Client 7 ' s BSP under " Rights Restrictions " it stated, " Because of [Client 7 ' s] self-management needs, his rights are restricted in the following areas: freedom from medication for behavior control. [Client 7] receives medication administered daily by staff. " The	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 312	Continued From page 29 BSP was absent of any information regarding the use of PRN behavior altering medication. Client 5 received PRN Olanzapine ODT 10 milligrams in tablet form on 2/6/16; 2/14/16; 2/20/16. PRN Quetiapine 100 milligrams (1/2 tab) was administered on 2/1/16; 2/6/16; 2/8/16; 2/9/16; 2/13/16; 2/14/16; 2/18/16; 2/20/16; 2/28/16; 2/29/16; 3/1/16; 3/2/16; 3/3/16; 3/4/16; 3/5/16;3/9/16; twice on 3/15/16. Per review of Client 5 ' s BSP it stated, " Staff may ask [Client 5] if he would like a PRN. When to call for a PRN - When [Client 5] asks. Ask if he would like a shot or oral. He will tell you. Often contacting nursing early increases threats and puts nursing/medication aides at risk of injury or increases [Client 5 ' s] risk for restraint. " Client 9 received PRN Hydroxyzine 25 milligrams on: 2/2/16; two times on 2/7/16; 2/8/6; 2/13/16; 2/14/16; 2/16/16; 2/20/16; 2/21/16 and 4/7/16. PRN Quetiapine was administered on 2/21/16; 2/23/16; 2/24/16; twice on 2/26/16; 2/27/16; twice on 2/28/16; 2/29/16; twice on 3/1/16; twice on 3/2/16; 3/8/16; 3/11/16; 3/14/16; 3/15/16; three times on 3/17/16; 3/22/16. PRN Clonazepam 0.5 milligrams was administered on 3/28/16; 3/29/16; twice on 3/30/16; 4/1/16; twice on 4/4/16; twice on 4/6/16; twice on 4/7/16; 4/9/16; 4/10/16; 4/11/16. PRN Lorazepam 1 milligram was administered once on 3/22/16. PRN Clonazepam 0.25 milligrams was administered once on 3/22/16. Per review of Client 9 ' s BSP implemented 3/15/16 there was no use to reference to how PRNs should be used.	W 312		
W 331	483.460(c) NURSING SERVICES	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 331	Continued From page 30 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide nursing intervention during end of life comfort care for one decedent, Client A. Findings include: During closed record review on 5/25/16 at 1:30 PM, an incident report dated 5/16/16 indicated that an assessment for pain and administration of comfort medication was not given to a patient with end of life Comfort 1 level orders. Client A had an order for Morphine to be given every hour as needed for comfort care of pain and air hunger. The incident report stated that Client A was given Morphine four times and Ativan two times on the overnight shift on 5/15/16 to 5/16/16, ending at 7 AM. During the morning shift, the nurse administered comfort medication at 1:30 PM, leaving the patient without the prescribed comfort medication for over six hours. When interviewed on 5/27/16 at 8:30 AM, the Director of Nursing (DON) said she was still investigating the incident, but it was her opinion that the comfort medications should have been administered earlier than the end of the morning shift.	W 331	**W-331** The facility must provide clients with nursing services in accordance with their needs. Client A. The Director of Nursing and other nursing staff will meet with local hospice agency on 6/22/16 to discuss integration of hospice services for clients at WLRC. Hospice training will provide competency based training to all nurses by 7/22/16 to include medication administration for comfort care. Responsible Person(s): Director of Nursing The nurses working in the Horizons Health Care Center will review each client's MAR during every shift change. All PRN usage will be reviewed during that shift. Responsible Person(s): Director of Nursing	7/22/16 6/16/16
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368	**W-368** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Client B.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 368	Continued From page 31 This STANDARD is not met as evidenced by: Based on interview and record review, the facility did not administer medication according to the prescriber ' s orders for one decedent, Client B. Findings include: During closed record review on 5/24/16 at 4:00 PM, a death report stated that Client B received 2 mg of Morphine three times when the order was written for 1 mg of Morphine. The report also stated that Morphine was improperly mixed with a form of saline that was not to be used for inhalation or nebulized morphine. When interviewed on 5/27/16 at 8:30 AM, the Director of Nursing (DON) said that the saline was clearly marked to be used in injections only. The DON stated the nurse who improperly mixed morphine with saline no longer worked at the facility.	W 368	**W-368 Continued** Root cause analysis diagram was completed and nurses will receive training. Responsible Person(s): QAPI Manager All nurses and medication aides will receive competency based training on policy Chapter 7, section 7 (Medication Administration). Retraining by July 15. Responsible Person(s): Director of Nursing All medication errors will be reported to a medical provider beginning 6/10/16. Nurses notified by email. Responsible Person(s): Director of Nursing All medication errors will be discussed at am clinic huddle to determine staff retraining. Patterns and trends of medication errors will be tracked by nurse manager and pharmacy and presented at monthly QAPI meetings. Responsible Person(s): Director of Nursing Responsible Person(s): Director of Nursing	7/15/16 7/15/16 6/10/16 6/20/16
W 376	483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on interview and record review, the facility did not implement the practice for reporting medication errors to the prescriber for three of four medication error reports. Findings include: During an interview on 5/27/16 at 11:30 AM, the	W 376	**W-376** The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53G003	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYONS ICF/MR AT WYOMING LIFE RESOURCE CENTER	8204 HIGHWAY 789 LANDER, WY 82520

(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
W 376	Continued From page 32 Director of Nursing (DON) said that all medication errors are not reported to the prescriber. The DON said that med errors are reported to the nurse and nursing judgment is used to indicate whether the prescriber is to be notified or not. Record review of four medication errors indicated that the provider was called in one of four cases according to the progress notes by the nurse. Review of the facility policy dated 5/6/10, Chapter 7: Section 7, titled Medication Administration stated when a medication error or adverse reaction is detected, the Registered Nurse is to be immediately notified and in turn notify the provider and the pharmacist.	W 376	**W-376 Continued** Root cause analysis diagram was completed and nurses will receive training. Responsible Person(s): QAPI Manager All nurses and medication aides will receive competency based training on policy Chapter 7, section 7 (Medication Administration). Retraining by July 15. Responsible Person(s): Director of Nursing All medication errors will be reported to a medical provider beginning 6/10/16. Nurses notified by email. Responsible Person(s): Director of Nursing All medication errors will be discussed at am clinic huddle to determine staff retraining. Patterns and trends of medication errors will be tracked by nurse manager and pharmacy and presented at monthly QAPI meetings. Responsible Person(s): Director of Nursing	7/15/16 7/15/16 6/10/16 6/20/16