DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/202
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53L003	A. BUILDING B. WING	08/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING BEHAVIORAL HEALTH	2521 EAST 15TH STREET , CASPER, Wyoming, 82609

(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
E0000	Initial Comments An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 8/10/26 through 8/12/26. Based upon the findings of the survey team it was determined the facility was in compliance with Federal requirements.	E0000		
N0000	Initial Comments A recertification survey was conducted by Healthcare Licensing and Surveys from 8/10/26 through 8/12/26.	N0000		
N0137	PROTECTION OF RESIDENTS CFR(s): 483.356(d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization. This ELEMENT is NOT MET as evidenced by: Based on medical record review, review of the patient and family handbook, and staff interview, the facility failed to ensure the policy for restraints and seclusion provided to the resident and/or the legal guardian contained contact information for the State protection and advocacy organization for 8 of 8 sample residents (#1, #2, #3, #4, #5, #6, #7, #8) who required contact information to be provided. The findings were: 1. Review of the medical record for sample residents #1, #2, #3, #4, #5, #6, #7 and #8 showed the guardian signed receipt of the resident's handbook on admission. 2. Review of the patient and family handbook showed the restraint and seclusion policy did not include contact information for the State protection and advocacy organization, nor was the information contained elsewhere in the handbook.	N0137		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	09/02/26

POC accepted. Message left on 9/4/26 @ 3:47pm for Michele Burnett, Assoc. Administrator. DOC – 9/8/26. Janelle Conley

JC

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N0137	Continued from page 1 3. Interview with the associate administrator on 8/11/26 at 3:26 PM confirmed the policy did not contain the contact information for the State protection and advocacy organization.	N0137		
N0222	EDUCATION AND TRAINING CFR(s): 483.376(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is NOT MET as evidenced by: Based on review of employee records, staff interview, and facility policy review, the facility failed to demonstrate cardiopulmonary resuscitation (CPR) competencies on an annual basis for 1 of 5 sample employees (#3), and restraint and seclusion competencies on a semi-annual basis for 3 of 5 sample employees (#1, #2, #3). The census was 24. The findings were: 1. Review of personnel files showed the following staff member did not have evidence they demonstrated competency in CPR on an annual basis: a. RN #3's CPR was issued 2/8/25, and there lacked evidence of competency since then. 2. Review of personnel files showed the following staff members did not have evidence they demonstrated competency in restraints and seclusion on a semi-annual basis: a. MD #1's restraint and seclusion competencies were issued 8/6/25 and lacked competency since then. b. RN #2's restraint and seclusion competencies were issued 1/9/26 and lacked competency since then. c. RN #3's restraint and seclusion competencies were issued 1/21/26 and lacked competency since then. 3. Interview on 8/12/26 at 10 AM with the human resources director revealed staff received CPR from the American Heart Association and were certified	N0222		

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N0222	Continued from page 2 for 2 years, and had not been doing yearly competencies as they did not realize that was a requirement. She stated staff had shown competency in that time period but it had not been documented. Further interview revealed staff had not been doing competencies for restraint and seclusion on a semi-annual basis, as they had never been told that was a requirement. She stated the staff constantly received education. 4. Review of the policy titled "General Orientation" last revised 3/26 showed "...2. Ongoing or Annual Required Trainings include A. CPR/First Aid B. Handle With Care Training..."	N0222		

Wyoming Behavioral Institute, CNN# 534004
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	By submitting this Plan of Correction, the Hospital does not agree that the facts alleged are true or admit that it violated the rules. The Hospital submits this Plan of Correction to document the actions it has taken to address the citations.	
N0137	**PROTECTION OF RESIDENTS:** **N0137, CFR(s): 483.356(d)** **CORRECTIVE ACTION:** Following the August survey Wyoming Behavioral Institute (WBI) Leadership Team reviewed the identified deficiency and PRTF state requirements. The Associate Administrator revised the Grievance Policy and the Grievance Process Notification Form to include the contact information, phone number and mailing address for the Wyoming Protection and Advocacy organization. This revised Grievance Process Form is included in the patient/family handbook and provided at admission The revised Grievance Policy and the Grievance Process Notification Form was reviewed by the Medical Executive Committee and approved by the Board of Governors. The CNO and Director of Intake and Assessment trained all Intake staff and Registered Nurses staff on providing all patients and/or legal guardians upon admission to WBI the revised Grievance Process Notification Form, included in the patient/family handbook, that includes state protection and advocacy agency contact information. Evidence of the training and staff understanding is documented on Attestations and filed in HR Files. **STAFF RESPONSIBLE**: Director of Intake and Assessment and CNO **MONITORING:** The Director of Intake and Assessment audits a minimum of 30% of all new admissions to ensure that revised Grievance Process Notification form, included in the patient/family handbook was provided to patients and guardians at admission. All deficiencies will be corrected immediately to include staff retraining as needed. Monitoring will continue for three months until compliance is achieved and sustained. Thereafter, 10% of new admissions will continue to be monitored monthly. The aggregated results of the Intake audit are provided to the Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	08/14/26 08/20/26 09/09/26 09/26/26 09/26/26

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N0222	**EDUCATION AND TRAINING:** **N0222, CFR(s): 483.376(F)**	
	CORRECTIVE ACTION: Wyoming Behavioral Institute (WBI) Leadership Team reviewed the identified deficiency and PRTF State requirements. The Leadership Team reviewed the General Orientation policy to include revisions to the current policy.	08/14/26
	The Director of Human Resources revised the General Orientation Policy to include the requirement that all direct care staff complete an annual required competency demonstration of CPR technique, as well as bi-annual competency on Restraint and Seclusion.	08/26/26
	The Associate Administrator revised the Proper Use and Monitoring of Restraint and Seclusion policy to include the required bi-annual training for direct care staff.	08/26/26
	The revised General Orientation Policy and the revised Proper Use and Monitoring of Seclusion and Restraint Policy were both reviewed in the Medical Executive Committee and approved by the Governing Body.	09/09/26
	The Staff Development Coordinator created a HealthStream (internal training platform) Class entitled "CPR Skills Demonstration" to enroll and notify staff of upcoming classes and add to staff training records.	09/02/26
	The Staff Development Coordinator added CPR skills demonstration training requirement to the Annual Required Trainings Tracking Spreadsheet, and developed a new Annual CPR Skill Demonstration Checkoff Form to document the completed training for direct care staff. Completed training forms will be filed in staff HR files.	09/02/26
	The Staff Development Coordinator enrolled all direct care staff in HealthStream Quarterly Seclusion and Restraint Re-Certification Class to meet the "semi-annual" training requirement. Per the revised hospital policy. Training included completion of competencies for each staff per hospital policy.	09/15/26
	The Director of Human Resources identified and developed a new tickler/tracking process. Supervisors will be notified 30 days prior to day of staff training/recertification due dates. Staff not found to be in compliance with required annual trainings, by expiration date, will not be scheduled to work by their supervisors, until they can demonstrate full compliance with training and hospital policies.	09/15/26

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N0222	**STAFF RESPONSIBLE:** Director of Human Resources, Staff Development Coordinator, CNO **MONITORING:** The Director of Human Resources will conduct a monthly review of all staff expiration dates for CPR and for Seclusion and Restraint training to ensure all identified staff have completed their required training or no scheduled to work until completed. Aggregated data is reported to the Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	09/26/26