STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535055	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARATOGA CARE CENTER LLC	**207 EAST HOLLY AVENUE / PO BOX 630 SARATOGA, WY 82331**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) was completed timely for 1 of 2 sample residents (#1) reviewed for PASARR screening. The findings were: 1: Medical record review showed resident #1 was admitted to the facility on [DATE] with a goal to remain at the facility for long-term care, and did not have a psychiatric [DIAGNOSES REDACTED]. Further review showed the resident was given a [DIAGNOSES REDACTED]. The following concerns were identified: a. Review of the PASARR Level I showed it was not completed until 12/2/19 and a PASARR Level II was not completed until 1/8/20. b. Interview with the Social Services Director (SSD) on 3/12/20 at 10:54 AM revealed the resident should have had a PASARR completed after s/he was given the psychiatric diagnosis. Further interview revealed the need for a PASARR was identified on 12/2/19, and it was completed that day. Upon identification, the SSD, director of nursing (DON), and minimum data sef (MDS) coordinator received training to ensure all of them could meet the requirements for PASARR completion. c. Interview with the DON on 3/12/20 at 11:55 AM revealed the previous Business Office Manager (BOM) was responsible for PASARR completion until she left the position in October 2019. Further interview revealed when the facility identified the untimely completion of the previous PASARRs at the start of December 2019, they developed a plan to identify and correct any other PASARRs that were not completed correctly and prevent future errors in PASARR completion. d. Review of the facility ' s Project Improvement Project (PIP) Guide, showed the facility developed a plan on 12/23/19 to identify all residents needing PASARR completion and began developing a system to prevent future errors in PASARR timeliness. Further review of facility-maintained PASRR audits showed the facility maintained an audit process to ensure timely PASARR completion; however, the facility had not successfully completed all needed PASARRs and LT101 Assessments by the survey date of 3/12/20.

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

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.