

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Casper Mountain Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4305 S Poplar Casper, WY 82601	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>37220</p> <p>Based on review of personnel records, staff interview, and medical record review, the facility failed to ensure the director of nursing was licensed by the State of Wyoming before providing nursing care to facility residents for 5 of 13 (#1, #2, #3, #4, #5) residents reviewed. The facility census was 74. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the former DON's personnel record showed she was hired on 3/11/24. There was no evidence the former DON had a valid Wyoming nursing license upon hire. The following concerns were identified: <ol style="list-style-type: none"> a. Review of the medical record for resident #1 showed an Abnormal Involuntary Movement Scale (AIMS) assessment was completed by the former DON on 3/19/24. b. Review of the medical record for resident #2 showed an Alert Charting Note had been completed by the former DON on 3/22/24. c. Review of the medical record for resident #3 showed a Braden Scale (assessment used for predicting pressure sore risk) was completed by the former DON on 3/19/24. d. Review of the medical record for resident #4 showed a medication reconciliation form had been completed by the former DON on 3/18/24. e. Review of the medical record for resident #5 showed medications had been added to the electronic medical record by the former DON on 3/25/24. 2. Interview with the chief of operations on 5/1/24 at 2:06 PM revealed the facility was aware the former DON did not have a Wyoming nursing license upon hire, and was only to be doing administrative duties until she was granted a license from the Wyoming Board of Nursing. Further, the former DON was recently terminated; however, she had been granted a license before she left. 3. Review of a License Verification Report showed the former DON was granted a Wyoming nursing license on 4/17/24. 4. Interview with the human resource director on 5/2/24 at 8:39 AM revealed the former DON's last day in the facility was 4/22/24. <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Casper Mountain Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4305 S Poplar Casper, WY 82601	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Interview with the nursing home administrator and interim DON on 5/2/24 at 10:25 AM confirmed the former DON had provided nursing care without a Wyoming nursing license.</p>