

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 03/06/2025
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>16146</p> <p>Based on resident, friend and staff interviews, and review of policies and procedures and incident reports, the facility failed to ensure the resident had the right to receive visitors of his/her choosing for 1 of 5 sample residents (#7) reviewed for residents rights/visitation. The findings were:</p> <ol style="list-style-type: none"> 1. During an interview on 3/5/25 at 3:20 PM resident #7 stated that his/her friend was no longer able to visit because the facility issued a no trespass order with the police. The resident stated in February his/her friend visited in the facility. When the friend was headed to the front door to leave, another resident accused resident #7 of hitting him/her when resident #7 wheeled by in the w/c. The resident stated s/he didn't hit the other resident. The resident stated his/her friend saw the whole thing and was yelling at that other resident [s/he] didn't hit you. Later, the police called the resident's friend and stated s/he was no longer allowed to visit because a no trespass order was issued by the facility. The resident was upset his/her friend was no longer able to visit. 2. On 3/6/25 at 10:24 AM the friend of resident #7 was interviewed. The friend stated s/he was told s/he was not allowed to visit anymore. The friend stated in February when s/he visited, another resident accused resident #7 of hitting him/her. The friend stated resident #7 did not hit the other resident. The friend stated s/he went up and tapped the other resident on the shoulder and told the resident that resident #7 did not hit him/her. 3. Review of an incident report reported to Healthcare Licensing and Surveys (HLS) showed on 2/9/25 at 6 PM resident #7 and resident #10 bumped into each other in the hallway and there were reports of them pushing each other. The report further read .Additionally, a visitor of one of the residents contributed to the situation by verbally expressing frustration toward the other resident. However, this visitor had left the premises before the arrival of the [NAME] Police Department. Law enforcement later contacted the visitor and informed [him/her] that [s/he] was no longer permitted to visit the facility. <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
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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on 3/6/25 at 3:28 PM the administrator stated the friend of resident #7 yelled at another resident and so a no trespass order was issued by the police. When asked if the visitor threatened the other resident, or was abusive, the administrator stated it did not rise to verbal abuse, but was disrespectful. When asked if this behavior was a pattern of the visitor, the administrator stated the visitor had previously disregarded some facility policies related to pets, but did not state the visitor had any other incidents of yelling at other residents. When asked if the facility had tried any other least restrictive measures to allow some visitation, such as supervised visits or visits only in the resident's room, the administrator stated no. He stated the facility had talked about setting up a meeting, but that meeting had not happened yet.</p> <p>5. Review of the facility's policy Resident Right to Access and Visitation (copyright date 2025) showed .The facility will provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time .Reasonable clinical and safety restrictions that protect the health and security of all residents and staff, which may include, but are not limited to: .d. Denying access or providing limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident . The facility's policy did not include restricting visitation for behavior that was disrespectful but not abusive.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>16146</p> <p>Based on medical record review, and staff and family interview, the facility failed to ensure the resident's physician was notified of a significant change in condition for 1 of 3 sample residents (#4) reviewed for changes in condition. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the 1/16/25 admission MDS assessment showed resident #4 had diagnoses including heart failure and diabetes mellitus and did not have any wounds. Review of progress notes dated 1/17/25 showed the resident did not have any edema and had no documented skin concerns. The following concerns were identified: <ol style="list-style-type: none"> a. Review of a skilled nursing evaluation dated 1/18/25 showed the resident had edema. The resident had +2 pitting edema to the right and left lower legs. b. Review of a skilled nursing evaluation dated 1/19/25 showed the resident had +1 pitting edema to the left lower leg and +2 pitting edema to the right lower leg. c. Review of skilled nursing evaluations dated 1/20/25 and 1/21/25 showed the resident had +1 pitting edema to the left lower leg. d. Review of a wound evaluation dated 1/21/25 showed the resident had a venous wound on the left foot which was being treated with Unna boots. Review of wound evaluations dated 1/28/25 and 2/4/25 showed the venous wound to the left foot remained. e. Review of the medical record showed no evidence the resident's physician was notified of the new edema to the lower legs nor the venous wound on the left foot. f. During an interview on 3/6/25 at 9:57 AM a family member stated the resident developed edema in the lower extremities while in the facility and also developed a wound on one foot. The family member stated s/he was not aware of the physician being notified. S/he stated a nurse notified the facility's wound team about the wound on the left foot. g. On 3/6/25 at 2:59 PM the DON stated a physician rounded with the wound care team, but it was not the resident's physician. She stated she was not sure if that physician communicated with the resident's physician. She also confirmed there was no physician orders for the wound care on the left foot. The facility did not provide any documentation to show the resident's physician was notified of the new edema on the legs and the wound to the left foot. 		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>16146</p> <p>Based on medical record review, staff and family interviews, and review of policies and procedures, the facility failed to ensure care was provided in accordance with physician orders and professional standards for non pressure-related wounds for 2 of 3 sample residents (#4, #7) reviewed for wounds. The findings were:</p> <p>1. Review of the 1/16/25 admission MDS assessment showed resident #4 had diagnoses including heart failure and diabetes mellitus and did not have any wounds. The following concerns were identified:</p> <p>a. Review of a wound evaluation dated 1/21/25 showed the resident had a venous wound on the left foot which was treated with Unna boots [type of compression bandage] and Coban. The evaluation was signed by a physical therapist.</p> <p>b. Review of a wound evaluation dated 1/28/25 showed the venous wound on the left foot remained and was being treated with Unna boots and Coban. The evaluation was signed by a physical therapist.</p> <p>c. Review of wound evaluation dated 2/4/25 showed the venous wound on the left foot remained. The treatment was changed to Cleanse with wound cleanser, apply zinc to bases, cover with bordered gauze. The evaluation was signed by a physical therapist.</p> <p>d. Review of the medical record showed no evidence the resident's physician was notified of the wound to the left foot.</p> <p>e. Further review of the medical record showed no evidence of physician's orders for the treatment of the wound.</p> <p>f. During an interview on 3/6/25 at 9:57 AM a family member stated the resident developed edema in the lower extremities while in the facility and also developed a wound on one foot. The family member stated s/he was not aware of the physician being notified. S/he stated a nurse notified the facility's wound team about the wound on the left foot.</p> <p>g. On 3/6/25 at 2:59 PM the DON stated a physician rounded with the wound care team weekly, but it was not the resident's physician. She stated she was not sure if that physician communicated with the resident's physician. She also confirmed there was no physician orders for the wound care on the left foot. She stated the physical therapist was the wound specialist and recommended the treatment. The facility did not provide any physician orders for wound care, nor evidence the resident's physician was notified of the wound.</p> <p>2. Review of the 1/17/25 admission MDS assessment showed resident #7 had a surgical wound. Review of a 1/15/25 progress note showed the resident had a surgical wound to the right thumb amputation site. The wound was covered and orders were to keep the dressing intact until a follow-up in 1 week with orthopedics. Review of a 1/23/25 progress note from orthopedics showed the resident was seen for follow-up for partial right thumb amputation. The examination showed the site was healing well and sutures were in place. The documented plan was for daily dressing changes and to return in 2 weeks. The following concerns were identified:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Review of the medical record showed no physician orders for daily dressing changes.</p> <p>b. Further review of the medical record showed no documentation that daily dressing changes were completed.</p> <p>c. During an interview on 3/6/25 at 2:59 PM the DON confirmed there were no physician orders for the daily dressing changes. She stated the facility had not seen that note from orthopedics until this week and the resident did not say anything when s/he returned from the appointment that day. She stated during that time period the resident would occasionally ask nursing staff for a band-aid.</p> <p>3. Review of the facility's policy Wound Treatment Management (copyright date at bottom of 2024) showed . Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change .in the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders .Treatments will be documented on the Treatment Administration Record or in the electronic health record.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>16146</p> <p>Based on medical record review, and staff and family interview, the facility failed to ensure the drug regimen was free from unnecessary drugs for 1 of 3 sample residents (#5) reviewed for medications. Resident #5 received a drug without adequate indication for its use. The findings were:</p> <p>1. Review of the 2/9/25 admission MDS assessment showed resident #5 had diagnoses which included history of falling and unspecified pain. The assessment further showed the resident did not have pain during the look-back period. Review of the original admission orders dated 2/3/25 showed an order for Tramadol 50 milligrams (mg), 1 tab, every 6 hours as needed [PRN] for pain. The instructions further read pt normally takes 1 tab at bedtime, but frequency was increased after a fall about a week prior to 1/28/25 admit to every [sic] 6 hours PRN. The following concerns were identified:</p> <p>a. Review of the February MAR showed the Tramadol order was transcribed as 50 mg every 6 hours. The order was put in as a routine order, and not as a PRN order. The order was in place until 2/14/25 when it was changed to every 6 hours PRN. Further review of the MAR for 2/3/25 through 2/14/25 showed the resident was given the Tramadol 7 times when his/her pain level was 0.</p> <p>b. Review of progress notes showed on 2/9/25 the family requested no scheduled Tramadol except at bedtime. The family requested scheduled Tylenol Arthritis.</p> <p>c. During an interview on 3/5/25 at 3:10 PM a family member stated the facility had been giving the resident Tramadol 4 times a day. The family member stated they noticed the resident was out of it so they requested the Tramadol not be given so much.</p> <p>d. On 3/6/25 at 2:59 PM the DON confirmed the order was for PRN, but was incorrectly transcribed as every 6 hours routinely.</p>		