| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to implement treatment to maintain or improve conditions for 1 of 4 sample residents (#1) reviewed with non-pressure wound care. This failure resulted in actually harm to resident #1 who was transferred to the hospital and treated for an infection related to the wound. The findings were:<br><br>1. Review of the admission MDS assessment dated [DATE] showed resident #1 admitted to the facility on [DATE] and had a BIMS score of 15 out 15, which indicated the resident was cognitively intact. The resident had diagnoses which included congestive heart failure, hypertension, renal insufficiency, benign prostatic hyperplasia, and encephalopathy. Further review showed the resident was at risk of pressure injury development with no pressure injuries present and no wounds, venous ulcers, or arterial ulcers present. The following concerns were identified:<br><br>a. Review of a physician note dated 3/27/25 showed the resident was seen for an initial evaluation of multiple wounds to his/her bilateral lower extremities. The wound assessment showed .1. RLE [right lower extremity] lateral non-pressure ulceration stage 2-onset 3/27/25 -16.0cm x [by] 8.0cm x 0.2cm - cluster of open areas with + [positive] slough, minimal granulation. Large amount of SS [serosanguious] drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 2. RLE [right lower extremity] anterior non-pressure ulceration - stage 2 - onset 3/27/25 -3.5cm x 2.5cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s [signs or symptoms] of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 3. RLE posterior non-pressure ulceration - stage 2 - onset 3/27/25 - 4.5cm x 1.0cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 4. LLE [left lower extremity] anterior non-pressure ulceration - stage 2 - onset 3/27/25 -0.6cm x 0.8cm x 0.1cm - 1 small open area with +slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 5. L 5th toe -stage 2 - onset 3/27/25 - 0.8cm x 0.5cm x 0.1cm - 1 small punched out appearing open area with m+ [sic] slough, no drainage. No odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are well-defined .<br><br>(continued on next page) |

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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | b. Review of a physician note dated 4/22/25 showed the resident was seen to evaluate the chronic BLE [bilateral lower extremities] venous ulcerations. The wound assessment showed .1. RLE lateral non-pressure ulceration - stage 2 - onset 3/27/25 -10.3cm x 7.5cm x 0.1cm - cluster of open areas with + slough, minimal granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 2. RLE anterior non-pressure ulceration - stage 2 - onset 3/27/25 -18.0cm x 13.0cm x 0.1cm - cluster of open areas with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 3. RLE posterior non-pressure ulceration - stage 2 - onset 3/27/25 -11.4cm x 9.0cm x 0.1cm - cluster of open areas with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 4. LLE anterior non-pressure ulceration - stage 2 - onset 3/27/25 -17.0cm x 15.0cm x 0.1cm - 1 small open area with + slough, moderate granulation. Large amount of SS drainage, no odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are not well-defined. 5. L 5th toe -stage 2 - onset 3/27/25 - 0.8cm x 0.5cm x 0.1cm - 1 small punched out appearing open area with m+ slough, no drainage. No odor, no erythema, no s/s of elevated bacterial burden. Peri-wound pink/edematous/moist. Wound edges are well-defined. 6. L Great toenail - the nail is only attached at the root. See below procedure. 7. R Great toe - stage 2 - onset 4/22/25 - 1.6cm x 3.2cm x 0.1cm - new onset circular open area d/t increased moisture exposure from large amount of drainage from BLE - +slough, light SS drainage, no erythema, no s/s of infection. 8. R foot 2nd toe - stage 2 - onset 4/22/25 - 3.0cm x 2.5cm x 0.1cm - small circular open area with +slough, light SS drainage, no erythema, no s/s of infection . The procedure indicated the resident's left great toenail was cut back to the root, betadine painted and wrapped with kerlix .<br><br>c. Review of a wound picture of the resident's left foot 5th toe dated 3/27/25 showed a yellow area near the toenail which measured 0.8 cm by 0.5 cm by 0.1 cm. Further review showed the resident's surrounding skin on his/her foot was pink in color, which was normal for him/her, with slight edema and there were no additional wounds observed at that time, the 5th toenail was light yellow; however, the other nails appeared normal in color.<br><br>d. Review of wound picture of the resident's left foot 5th toe dated 4/22/25 showed a yellow/brown area near the toenails which measured 0.8 cm by 0.5 cm by 0.1 cm. The review showed the resident's foot appeared darker in color with more edema present and the resident's 5th toenail was dark yellow. Further review showed open areas to the 3rd toe and great toe and a discoloration present on the 4th toe which was red, yellow, orange, and brown in color. Review of a wound picture for the resident left foot 3rd toe dated 4/22/25 showed the open area had a light pink wound bed which appeared wet, the edges appeared to be rolled up and were white with some yellow discoloration noted. The wound measured 1.5 cm by 2.3 cm by 0.1 cm. The review showed an open area on the 2nd toe near the nail bed and an open area on the nail bed of the great toe where a large portion of the nail had been removed. Further review showed discoloration to 2nd toenail with a dark area near the cuticle and large dark discoloration on the tip of the great toe. Review of a picture of the resident's left foot 2nd toe showed the open area measured 1.9 cm by 1.0 cm by 0.1 cm. Further review of the resident's medical record showed no evidence the open area to the resident's great toe, where the toenail was missing, was measured.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | e. Review of a wound picture of the resident's right lateral leg dated 3/27/25 showed scattered areas which varied in color including yellow, red, and pink. The yellow areas were located near the resident's ankle and the surrounding tissue appeared normal in color for the resident. Further review showed the area measured 16.0 cm by 8.0 cm by 0.2 cm. Review of a wound picture of the resident's right anterior leg dated 3/27/25 showed an area which had scattered open areas and the wound beds were red in color. Further review showed the area measured 3.5 cm by 2.5 cm by 0.1 cm and the surrounding skin was normal for the resident. Review of a wound picture of the resident's right posterior leg showed an area with some light brown discoloration and the area measured 4.5 cm by 1.0 cm by 0.1 cm. Further review showed the surrounding skin was normal for the resident.<br><br>f. Review of a wound picture of the resident's right lateral leg dated 4/22/25 showed a large open area with a bright red wound bed. There were small scattered areas that appeared pink with yellow edges and some with white tissue. Further review showed the wound appeared wet and measured 18 cm by 13 cm by 0.1 cm. Review of a wound picture of the resident's right posterior leg dated 4/22/25 showed the wound bed bright red with area of shiny white tissue. The wound bed appeared wet and draining. Further review showed the wound measured 11.4 cm by 9.8 cm by 0.1 cm.<br><br>g. Review of a wound picture of the resident's left anterior leg dated 3/27/25 showed an open area with a wound bed that was yellow and slightly tan in color. Further review showed the area measured 0.6 cm by 0.8 cm by 0.1 cm.<br><br>h. Review of a wound picture of the resident's left anterior leg dated 4/22/25 showed a large open area that was bright red and dark red in color. There were other areas of intact tissue in the wound bed that had yellow and white color. The wound appeared wet with drainage noted and measured 17.0 cm by 15.0 cm by 0.1 cm.<br><br>i. Review of a wound picture of the resident's right 2nd toe showed the resident's toenail was dark yellow in color and there was an open area which had a white wound bed. The surrounding tissue was darker in color and the wound appeared to be draining fluid. Further review showed the wound measured 3.0 cm by 2.5 cm by 0.1 cm. There were no previous pictures of the right 2nd toe wound in the medical record.<br><br>j. Review of a wound picture of the resident's right great toe dated 4/22/25 showed the toenail was very thick and yellow with some black areas noted to the lateral nail fold. Further review showed an open area on the top of the foot with a slightly yellow wound bed and white tissue surrounding the wound and an area on the later toe which was white and yellow in color. The tip of the resident's toe was bright red in color. Further review showed the wound measure 1.6 cm by 3.2 cm by 0.1 cm. There was no previous picture of the right great toe in the medical record.<br><br>k. Review of the progress notes showed no evidence of wound monitoring or identification of new wounds.<br><br>j. Review of the TAR for April 2025 showed resident #1 had an order for .Saturate Kerlix with Vashe and wrap R leg and L leg for 15min followed by light scrub. Pat dry. [NAME] Lotion to legs. K2 Lite [compression wraps] to both legs starting at base of toes to below knee. one time a day every Fri for wound care which began on 4/3/25. The review showed treatments on 4/4 and 4/18 were performed by a MA-C and no treatment was performed on 4/11 or 4/25. Further review showed no evidence of as needed dressing changes, refusals of dressing changes, or dressing changes performed by the wound team.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | l. Interview with MA-C #1 on 5/16/25 at 10:38 AM revealed she was not able to perform wound measurements or assessment because she was not a nurse. Further interview revealed the wound team measured and assessed wounds on Tuesdays. Interview with MA-C #1 on 5/16/25 at 11:43 AM revealed the resident's wounds had gotten worse during his/her stay and as needed dressing changes and refusals of dressing changes should be documented on the treatment administration record.<br><br>m. Review of a hospital history and physical note dated 4/25/25 and timed 9:46 PM showed the resident arrived to the hospital in very poor condition and his/her dressing to the bilateral lower extremities were saturated. The resident reported increasing leg pain with his/her right leg being worse than the left. The note showed .On arrival [s/he] was noted to be covered in feces, [s/he] had dressings on [his/her] lower extremities that were feces soaked as well. Patient is supposed to have wound care changes every Tuesday but [s/he] is unclear when [his/her] last change was . The physical exam showed .[his/her] lower extremities have wounds from the knees down, skin is sloughed off, [his/her] right lower extremity is erythematous up to med thigh, [s/he] has wounds on [his/her] toes. No heel wounds . The Assessment/Plan showed .Sepsis (WBC, HR) Right lower extremity cellulitis. Likely secondary to multiple lower extremity wounds. Follow-up blood cultures. Wound care consult for wounds. Continue vancomycin and ceftriaxone .<br><br>2. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed if wound care was not performed or if additional PRN [as needed] dressings were performed, the nurse should document the care in the progress notes or in a note on the TAR. She revealed she was not able to oversee wound care in the facility and the facility did not have a staff performing oversight for the wound program. Further interview confirmed both residents experienced wound deterioration.<br><br>3. Review of the facility policy titled Wound Treatment Management dated 2024 showed .8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. lack of progression towards healing. b. Changes in characteristics of the wound . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and scope of practice review, the facility failed to ensure staff provided care appropriate for their scope of practice for 2 of 6 sample residents (#1, #14) reviewed for wound care. The findings were:<br><br>1. Observation on 5/16/25 at 10:38 AM showed MA-C #1 entered the room of resident #14. The MA-C performed hand hygiene, donned gloves, and placed a barrier under the resident's legs. She removed a dressing on the resident's left shin which exposed an open wound with visible discoloration and a pudding thick discharge which was yellow in color. The MA-C applied Vashe solution (hypochlorous acid) on a gauze pad and placed the gauze on the wound which she told the resident had to sit for 10 minutes. The MA-C doffed her gloves and washed her hands, donned clean gloves, and applied lotion to right leg. The MA-C removed her gloves and washed her hands, donned clean gloves, and removed the gauze from the resident's left shin wound. At that time, the yellow drainage was gone and the wound appeared red with dark colored edges. The staff member patted the wound bed with gauze then applied a border gauze. The MA-C doffed her gloves and donned clean gloves, removed xeroform (petrolatum and bismuth tribromophenate impregnated gauze), cut off a small section, placed it on the resident's left toe wound, and covered the wound with gauze. The MA-C doffed her gloves, donned clean cloves, wrapped the resident's left foot with kerlix, and secured the wrap with tape. Interview with the MA-C at that time she did not perform measurements or an assessment on the wounds due to not being a nurse. Further interview revealed the wound team measured and assessed wounds on Tuesdays.<br><br>2. Review of the treatment administration record for April 2025 showed resident #1 had an order for .Saturate Kerlix with Vashe and wrap R leg and L leg for 15min followed by light scrub. Pat dry. [NAME] Lotion to legs. K2 Lite [compression wraps] to both legs starting at base of toes to below knee. one time a day every Fri for wound care which began on 4/3/25. The review showed treatments on 4/4 and 4/18 were performed by a MA-C and no treatment was performed on 4/11 or 4/25.<br><br>3. Interview with MA-C #1 on 5/16/25 at 11:43 AM revealed she was unsure if the Vashe treatment was medicated; however, she confirmed she performed the treatments for resident #1 and resident #14 and she performed wound care for residents who had topical medications applied.<br><br>4. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed she was attempting to find competencies for MA-Cs to demonstrate their ability to perform wound care and she revealed MA-Cs were able to perform wound care which did not include applying topical medication. No MA-C wound competencies were provided by the facility. She confirmed the Vashe solution and xeroform would be topical medications and revealed she had not researched the treatments to determine what was a topical medication. Further interview revealed an RN did not complete a wound assessment prior to wound care by a MA-C.<br><br>5. Review of the Wyoming State Board of Nursing advisory opinion titled CNA II Role & Course Requirements last revised June 2024 showed .Wound Care (only after assessment by a provider or RN) . *The CNA II is NOT allowed to apply medication to any wound, including topical medications .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6. Review of the Wyoming State Board of Nursing advisory opinion titled Medication Assistant-Certified (MA-C) last revised August 2024 showed .Role of the MA-C: The role of the Medication Assistant-Certified Role (MA-C), in addition to all functions of the CNA, is as follows provide routine medications by the following routes: oral, inhalation (nebulizer treatments must be pre-measured), topical, instillation into the eyes, ears, and nose, rectal, vaginal . Further review showed no evidence the topical medication could be applied to an open wound during dressing changes. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casper Mountain Rehabilitation and Care Center | 4305 S Poplar<br>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) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure enhanced barrier precautions were implemented for 1 of 2 sample residents (#14) during wound care. The findings were:<br><br>1. Observation on 5/16/25 at 10:38 AM showed MA-C #1 entered the room of resident #14. The MA-C performed hand hygiene and donned gloves and performed wound care for the resident. Observation showed the resident had wound care performed to an open wound on his/her left shin and an open area to one of his/her left toes. Observation showed a plastic container which contained personal protective equipment, including gowns, was located near the resident's bed. Further observation showed the MA-C did not wear a gown during the wound care.<br><br>2. Interview with the infection preventionist/staff development coordinator on 5/16/25 at 1:22 PM revealed enhanced barrier precautions should be used for all residents with wounds, catheters, and dialysis or other types of ports. Further interview revealed gloves and gowns should be worn for enhanced barrier precautions during wound care and she confirmed resident #14 was on enhanced barrier precautions.<br><br>3. Review of the policy titled Enhanced Barrier Precautions provided by the infection preventionist/staff development coordinator on 5/16/25 showed .2 .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcer) .even if the resident is not known to be infected or colonized with MDRO [multi-drug resistant organism] . |