STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This requirement was not met as evidenced by: Based on medical record review, and staff, and resident interview, the facility failed to evaluate hazards and risks or identify and implement measures to reduce the hazards/risks as much as possible for 1 (#15) of 6 sample residents. The findings were: Review of the 9/22/25 quarterly MDS assessment showed resident #15 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included diabetes mellitus, morbid obesity, muscle weakness, and gout. Further review showed the resident had functional limitations of the lower extremities, and required the use of an electric wheelchair (w/c). The following concerns were identified:1. Interview with the resident on 12/29/25 at 3:33 PM revealed that s/he had caught his/her leg in the courtyard doorway at the facility while in his/her wheelchair in June 2025 and sustained a fractured leg. a. Review of the orthopedic physician's note dated 6/26/25 showed the resident had reported right ankle and leg pain after getting his/her foot caught on the facility door. b. Review of the resident's X-ray results of his/her right tibia and fibula dated 7/1/25 showed.1. An acute, nondisplaced oblique fracture through the distal tibial diaphysis. 2. Review of a skin injury note dated 10/28/25 and timed 12:30 PM showed the resident had sustained a large bruise to his/her left calf after bumping his/her leg into a bed. Interview with the resident on 12/29/25 at 3:33 PM confirmed that s/he had hit his/her leg on his/her bed in October while in an electric wheelchair.3. Interview with the Physical and Occupational Therapy Director on 12/30/25 at 1:35 PM revealed there was not a wheelchair skill, or safety assessment completed on the resident, following the right leg fracture in June 2025, or after bumping his/her left leg on 10/28/25.4. Review of the care plan dated 11/6/25 showed the resident mobilized independently in a motorized w/c. An intervention to educate the resident on the proper use of mobility devices was initiated on 5/29/25. There were no additional interventions to address w/c safety. 5. Interview with RN # 8 on 12/29/25 at 3 PM confirmed that safety assessments should have been completed on all residents who required power wheelchairs.

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