

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, facility incident review, and policy and procedure review, the facility failed to ensure hot liquids were at a consumable temperature to prevent accident hazards for 1 of 5 sample residents (#59) reviewed for accident hazards. This failure resulted in actual harm to resident # 59 who received a burn from hot liquid that was provided by staff. The failure resulted in a determination of immediate jeopardy due to a lack of implementation of preventative measures. The census was 70. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #59 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included difficulty swallowing, diabetes mellitus, peripheral vascular disease, anxiety, depression, and a history of bilateral below the knee amputation. Further review showed the resident was dependent upon staff for bed mobility such as, sitting on the side of the bed from a lying position. Review of the care plan last revised on 12/30/24 showed the resident was independent with eating. The following concerns were identified: a. Review of the incident report dated 7/12/26 and timed 11 AM showed the resident .was eating a bowl of green chili, and tried to adjust in bed and spilled on [his/her] right thigh. Further review showed s/he had obtained redness and a nickel sized blister to the right thigh. b. Interview with resident #59 on 7/14/26 at 9:02 AM confirmed s/he had spilled a cup of green chili on him/herself while eating in bed on 7/12/26 which caused a blister on his/her right thigh. S/he revealed the chili had been served in a Styrofoam cup and while holding it, his/her thumb went through the cup, which resulted in the resident dropping the cup, and spilling the contents on his/her lap.c. Observation on 7/14/26 at 9:10 AM showed a dressing on the resident's right thigh dated 7/12/26. d. Interview with RN #1 on 7/14/2026 at 6:03 PM revealed she had made her own green chili at home, and would often bring it into the facility in a crock pot to share with the residents. She revealed she left the crock pot on the warm setting at 6 AM and did not check the temperature prior to serving it to the resident at 11 AM. Further interview confirmed she had served the green chili in a Styrofoam cup and when she returned to the resident's room at 11:15 AM she observed the green chili had spilled on the resident's thigh, which caused redness and blistering. 2. Review of the policy titled Food Safety last revised 5/1/24 showed The facility must .store, prepare, distribute and serve food in accordance with the professional standards of food service safety. 3. Review of the policy titled Hot Liquids last revised 5/4/26 showed The food provided by the facility should be palatable, attractive, and at an appetizing temperature as determined by the type of food to ensure resident's satisfaction, while minimizing the risk for scalding and burns. and Liquid Temperature and Burn Considerations .burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at risk for burns caused by scalding. These conditions include: (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: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reaction time), decreased cognition or dementia, decreased mobility and decreased ability to communicate. The degree of injury depends on factors including water temperature, the amount of skin exposed, and the duration of exposure. 4. Interview with the DON on 7/14/26 at 11:53 AM revealed the facility was monitoring the resident's burn following the incident, however denied implementation of interventions for reoccurrence or that an investigation had been completed. 5. On 7/14/26 at 3:40 PM the regional vice president, the facility administrator, the regional director of clinical services, and the facility director of nursing were informed of an immediate jeopardy related to a failure to identify and remove accident/hazard risks to residents. 6. The facility submitted a removal plan on 7/15/26 at 9:40 AM which included: a. A root cause analysis was performed regarding the incident and identification of non-adherence to outside food temperature policy and microwave food safety serving temperatures was identified on 7/14/26. b. All at risk residents, including resident #59 were reviewed and assessed for adaptive equipment and the ability to manage self-feeding. Residents who required adaptive equipment were referred to occupational therapy for further evaluation on 7/14/26. c. An ADHOC Quality Assurance/Performance improvement meeting was held with the medical director in attendance on 7/14/26. d. 1 to 1 education was provided to RN #1 on 7/14/26. e. Education was provided for nursing staff on 7/14/26 regarding the facility policy and procedures related to outside food brought into the facility, safe food temperatures not exceeding 155 degrees Fahrenheit for consumption, and reheating hot liquids. Further education included, serving food in appropriate containers to meet the residents needs and allowing food to cool to 155 degrees Fahrenheit prior to serving to residents. f. Temperature logs and thermometers were posted at each unit microwave on 7/14/26. g. All remaining nursing staff would be educated prior to their next scheduled work shift. 7. The removal plan was accepted on 7/15/25 at 9:49 AM. 8. The implementation of the removal plan was verified and immediacy was removed on 7/15/26 at 2:42 PM; however, deficient practice remained at a scope and severity of G.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on resident and staff interview, grievance form review, and policy and procedure review, the facility failed to ensure the views of a resident or family group were considered and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The census was 70. The findings were:1. Interviews with 15 residents who attended resident council meeting on 7/14/26 at 2:10 PM revealed most residents felt staff did not follow up on their grievances with a resolution.2. Review of 22 grievance forms regarding missing personal items, water temperature, nursing, and staffing concerns over the last 4 months revealed 7 of the 22 grievances lacked documentation showing a resolution or follow-up outcome with the resident or representative.3. Interview with the administrator revealed no specific timeline for grievance resolution. The administrator stated the facility allowed the laundry department additional time to locate missing clothing, but attempted to resolve nursing or missing money concerns immediately. During the interview, this surveyor presented the administrator with several unresolved grievance forms dating back to 3/13/26 that lacked documented resident or representative follow-up. Upon this surveyor's request for these forms, the administrator immediately resolved two grievances regarding missing blankets, one from 3/13/26 and one from 5/13/26 by purchasing a replacement blanket for one resident that day and agreeing to reimburse another resident's daughter for reordering a replacement. The administrator reviewed the remaining grievance forms and confirmed that staff did not always resolve grievances in a timely manner. 4. Review of the facility policy titled Grievance Program (Concern and Comment) last revised 6/15/22 showed .1. b. A reasonable expected time frame for completing the review of the grievance . Following up with resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction.Executive Director and/or Designee is responsible for the following: .Ensuring that all grievances and Concern & Comment Reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated, achieved and maintained.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a pharmaceutical services procedure related to accurate acquiring, receiving, dispensing and administration of medications for 1 of 3 sampled residents (#17) reviewed for medication availability. The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #17 had a (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included urinary tract infection, heart failure, high blood pressure, anemia, atrial fibrillation, anxiety disorder, respiratory failure, and shortness of breath. Further review of the nursing progress note dated 4/14/26 and timed 3:53 PM showed the resident was sent to the emergency room for shortness of breath and low oxygen saturation. The following concerns were identified: a. Review of the medical record showed the resident was admitted on [DATE] at 4:30 PM. Review of the progress note dated 4/13/26 and timed 5:29 PM showed the resident did not receive his/her diltiazem, gemfibrozil, and methocarbamol because it wasn't available. Review of the nursing progress note dated 4/13/26 and timed 6:15 PM showed the facility did not have any of [his/her] medications at this time and [s/he] verbalized understanding. Review of the progress note dated 4/13/26 and timed 11:34 PM showed the resident did not receive his/her Bactrim [antibiotic] because it wasn't available. Review of progress note dated 4/13/26 and timed 11:35 PM showed the resident did not receive his/her simvastatin because it wasn't available. Review of progress note dated 4/13/26 and timed 11:36 PM showed the resident did not receive his/her propranolol or primidone because it wasn't available. Review of a progress note dated 4/13/26 and timed 11:37 PM showed the resident did not receive his/her pantoprazole or methocarbamol because it wasn't available. Review of progress note dated 4/13/26 and timed 11:38 PM showed the resident did not receive his/her famotidine because it wasn't available. Review of progress note dated 4/13/26 and timed 11:39 PM showed the resident did not receive his/her AZO cranberry or apixaban because it wasn't available. Review of progress note dated 4/13/26 and timed 11:41 PM showed the resident did not receive his/her diltiazem because it wasn't available. Review of progress note dated 4/13/26 and timed 11:45 PM showed the facility was unable to give medications as not available, outside pharmacy did not bring any .and would not add [him/her]. Resident aware. Review of the progress note dated 4/14/26 and timed 9:04 AM showed the resident did not receive his/her AZO cranberry or gemfibrozil because it was On supply from the pharmacy. Review of the medication administration record confirmed the resident had not received the medications. b. Interview with the DON on 7/15/26 at 4:07 PM revealed the resident was admitted with medication orders which should have been sent to the contracted pharmacy. He confirmed the resident had missed medication doses, but could not provide a rationale. Further interview revealed nursing staff were expected to pull medications from the facility's emergency 'kit located in the Omnicell (An automated, computerized cabinet or system used in hospitals and healthcare facilities to securely store, manage, and dispense medications and medical supplies) if the contracted pharmacy had not sent them to the facility. c. Interview with the DON on 7/16/26 at 2:17 PM revealed the facility admissions team was responsible for sending medication orders to the primary pharmacy, but could not provide evidence the admissions team had sent the orders. Further interview revealed if the pharmacy couldn't deliver the medications to the facility, the prescriptions should have been sent to a local contracted pharmacy until the primary pharmacy could deliver them to the facility. d. Interview with the admissions director on 7/16/26 at (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:24 PM revealed the resident's medication orders should have been faxed to the primary pharmacy prior to the resident's admission and a call should have been placed to verify the pharmacy had received them, but she could not provide evidence the orders were faxed. e. Interview with LPN #1 on 7/16/26 at 4 PM confirmed the facility had not received the resident's medications from the pharmacy and she did not pull the medications from the emergency kit located in the Omnicell. 2. Review of the policy titled Medication Shortages/Unavailable Medications last revised 8/1/24 showed .3. If a medication is unavailable or discovered after normal pharmacy hours.A facility nurse should obtain the ordered medication from the Emergency Medication Supply, the licensed facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include.Emergency delivery or use of an emergency (back-up) third party pharmacy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 5 sample residents (#4) observed for resident care. The findings were: 1. Observation on 7/15/26 at 3:56 PM showed CNA #2 and CNA #1 entered resident #4's room with a mechanical lift. The CNAs attached the lift sling to the mechanical lift and without applying gloves or other personal protective equipment. CNA #2 used her ungloved left hand to lift the resident's catheter drainage bag. The CNA hung the drainage bag on the mechanical lift and CNA #1 lifted the resident out of the recliner and positioned the lift over the resident's wheelchair. Without performing hand hygiene, CNA #2 grabbed the resident's wheelchair handles to reposition and stabilize the chair. At that time, CNA #1 lowered the resident into the wheelchair and without wearing gloves, CNA #1 used her ungloved hand to remove the drainage bag from the mechanical lift and positioned it under the resident's wheelchair. Without performing hand hygiene, the CNAs prepared the resident to exit the room by touching his/her pants, shirt, wheelchair foot pedals, and the mechanical lift controls. Observation showed CNA #2 exited the room pushing the resident's wheelchair and CNA #1 pushed the mechanical lift into the hall. Further observation showed no hand hygiene was performed before exiting the room. 2. Interview with the infection preventionist on 7/16/26 at 10:17 AM revealed enhanced barrier precautions should have been used when providing care to a resident with a catheter, even during a mechanical lift transfer. She revealed she expected hand hygiene to be performed after touching a catheter drainage bag and before exiting a resident's room. 3. Review of the policy titled Indwelling Urinary Catheter (Foley) Management last revised on 9/4/25 showed . General Urinary Catheter Maintenance Guidelines .3. Use personal protective equipment, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collection system . 4. Review of the policy titled Hand Hygiene last revised on 7/15/22 showed . When to perform proper hand hygiene with (ABHR) and with soap and water; Before and after all resident contact; After contact with potentially infectious material; After contact with objects in the resident's room; It is important to make sure that hand hygiene is performed at the appropriate times before and after touching a resident, between residents and frequently during care .		