STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lincoln Nursing Center	711 Onyx St Kemmerer, WY 83101

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of medical records, staff interview, policy and procedure review, and review of the State Survey Agency incident database, the facility failed to ensure injuries of unknown source were reported to the State Agency within the required timeframe for 2 of 2 residents (#1, #2) reviewed for unexplained injuries. The census was 16. The findings were: 1. Review of the facility's policy Abuse Prohibition, last reviewed December 2019, showed Reporting/Response 1. General Guidance: Alleged violations, including injuries of unknown source, will be reported immediately to the Administrator or designee and the investigative Task Force which consist of the Administrator, Risk Manager, Compliance Officer, and the immediate supervisor of the employee being investigated. Corrective action will be taken depending on the results of the investigation. 2. Time frames: Alleged violations will be reported to the Office of Healthcare Licensing and Surveys and the Department of Family Services within 24 (twenty-four) hours of the allegation. All allegations of abuse will be reported and the results of the investigation will be reported to the appropriate agencies within 5 (five) working days of the incident. The following concerns were identified: a. Review of a 12/4/25 nurse progress note for resident #1 showed the following:i. At 0407 (4:07 AM) this RN was in another resident's room when the CNA on shift came to this RN and stated I think you should come take a look at [resident room number], [s/he] is complaining of pain on the left side of [his/her] chest and screamed out when I rolled [him/her] to change [his/her] brief.ii. A 4:10 AM progress note showed the resident rated his/her pain at an 8 out of 10 and the pain was sharp. The resident explained to the RN that s/he was getting up yesterday morning and that is when it started hurting, noting that it hurt when [s/he] got up in the sit-to-stand. iii. A 4:27 AM progress note showed the on-call provider was called and informed of the resident status, and the resident said the pain was sharp .but that resident was in pain at this time without any activity and that resident screamed when changed this morning and that this did not occur when changed earlier in the night.iv. A 4:55 AM progress note showed the resident was transferred to the emergency department for an evaluation.v. A 6:34 AM progress note showed the nurse had received a report from the emergency department, had been diagnosed with a chest wall contusion, and had been prescribed Lortab (hydrocodone/acetaminophen) for pain management. b. Review of a 12/29/25 nurse progress note for resident #2 showed It was reported to this RN that resident had some bruising around [his/her] anus. This RN assessed and found that there is bruising around [his/her] anus. The bruising is red/purple in color. 2. Review of the State Agency incident database showed no incidents had been reported since 4/26/25. 3. Interview with the DON on 1/6/26 at 4:05 PM revealed the facility's policy had not been followed and confirmed no incidents had been reported to the state agency since April of 2025.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review, staff and resident interview, and policy and procedure review, the facility failed to initiate an investigation following an injury of unknown source for 2 of 2 residents (#1, #2) reviewed for unexplained injuries. The census was 16. The findings were: 1. Review of the 12/8/25 quarterly MDS assessment showed resident #1 had a BIMS score of 12 out of 15 (mild cognitive impairment); weighed 232 pounds; had not had any falls since the last assessment; required substantial/maximal assistance from staff for the mobility activities of daily living of rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and transfers from a chair/bed-to a chair. The resident was totally dependent on staff for toilet transfers. The following concerns were identified: a. Review of RN #1's progress notes on 12/4/25 showed the following: i. At 0407 (4:07 AM) this RN was in another resident's room when the CNA on shift came to this RN and stated I think you should come take a look at [resident room number], [s/he] is complaining of pain on the left side of [his/her] chest and screamed out when I rolled [him/her] to change [his/her] brief. ii. A 4:10 AM progress note showed the resident rated his/her pain at an 8 out of 10 and the pain was sharp. The resident explained to the RN that s/he was getting up yesterday morning and that is when it started hurting, noting that it hurt when [s/he] got up in the sit-to-stand. iii. A 4:27 AM progress note showed the on-call provider was called and informed of the resident status, and the resident said the pain was sharp .but that resident was in pain at this time without any activity and that resident screamed when changed this morning and that this did not occur when changed earlier in the night. iv. A 4:55 AM progress note showed the resident was transferred to the emergency department for an evaluation. v. A 6:34 AM progress note showed the nurse had received a report from the emergency department, the resident had been diagnosed with a chest wall contusion, and had been prescribed Lortab (hydrocodone/acetaminophen) for pain management. b. Review of the emergency department evaluation showed the resident .presents to the emergency department with left-sided chest wall pain that began after an aide rolled him 3 days ago. The patient requires almost 100% assistance to move. [The resident] localizes the pain just below [his/her] left breast. [The resident] states the pain is worse with changing positions or using [his/her] left arm or pushing on this region even taking in a big breath can make it worse. It is most painful when [s/he] is being moved . The emergency department note showed Patient was given a Lortab 5 mg pain medication. [His/her] pain localizes to [his/her] chest wall, reproducible with palpation and use of [his/her] left arm. As [s/he] is difficult to position for X-ray imaging we will do a CT to rule out rib fractures. CT of the chest does demonstrate both evidence for left and right anterior chest wall contusions . c. Review of a 12/5/25 nurse progress note, written by RN #3, showed the resident's representative was upset that staff were transferring [the resident] without the stand-up lift . [the resident's representative] feels like this has contributed to chest pain. In addition, the note showed This RN spoke with [physical therapist] and he reports that he was unable to work with [the resident] today due to him being in a lot of pain, causing difficulty in sitting up so he rescheduled for Tuesday. He will evaluate for safe transfers at that time. Staff instructed to use stand up lift till that time. d. Review of a 12/7/25 nurse progress note, written by RN #2, showed Resident continues to complain of chest wall pain and is utilizing [his/her] PRN (as needed) Hydrocodone 5/325 mg. [The resident] rated it a 6/10 tonight. [The resident complained of [his/her] care and attitudes from staff and called [his/her] daughter. [The resident] reported that [his/her] daughter was coming tomorrow ant that [s/he] was leaving. e. Review of a 12/8/25 progress note, written by RN #2, showed Resident continues to complain of pain and is taking [his/her] Hydrocodone PRN. When assessed the resident [s/he] had no bruising on [his/her] chest currently. [The resident] (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continues to be concerned about [his/her] care and stated that [s/he] does not want [CNA #2] in [his/her] room period. [The resident] stated that [his/her] daughter has expressed this wish as well. [The resident] stated to this RN that [s/he] is not leaving because [his/her] daughter does not want [him/her] too (sic). Will report to administrative nurses . f. Interview with the resident on 1/6/26 at 8:42 AM revealed s/he sometimes clashes with CNAs but it was taken care of. The resident stated approximately 6 weeks ago a CNA had grabbed him/her around the chest during a transfer and then indicated the area on his/her left upper chest was still sore. The resident was unwilling to share any further information. g. Telephone interview with RN #2 on 1/6/26 at 3:34 PM revealed she had not witnessed any event that led up to resident #1's injury; however, the resident had told her CNA #2 had transferred him/her without using the sit-to-stand lift. RN #1 stated she had emailed the DON and RN #3 to inform them of the allegation. 2. Review of the 12/9/25 quarterly MDS assessment showed resident #2 had a BIMS score of 5 out of 15 (severe cognitive impairment); required substantial/maximal assistance for the mobility activity of rolling left and right and was totally dependent on staff for sitting to lying; chair/bed-to-chair transfers, toilet transfers and tub/shower transfers. The following concerns were identified: a. Review of 12/29/25 nurse progress note, written by RN #2, showed It was reported to this RN that resident had some bruising around [his/her] anus. This RN assessed and found that there is bruising around [his/her] anus. The bruising is red/purple in color. b. Review of a 12/30/25 nurse progress note, written by RN #2, showed Resident is alert and oriented to person and place. [S/he] has a hard time remembering staff names but not faces. [S/he] is transferred via Hoyer. [S/he] is mobile via staff in a wheelchair. [S/he] does have some bruising around [his/her] anus that is going away. 3. Review of the facility documentation showed no evidence the injuries of unknown source had been investigated. 4. Interview with the chief compliance officer on 1/6/26 at 2:34 PM revealed he had consulted the safety officer and an occurrence report related to resident #1 had not been received. 5. Interview with RN #3 on 1/6/26 at 2:45 PM revealed the facility did not track injuries of unknown origin. 6. Interview with the DON on 1/6/26 at 4:05 PM revealed the facility's policy had not been followed and occurrence reports had not been filed related to the injuries of unknown source. 7. Review of the Abuse Prohibition policy, provided by the chief compliance officer, showed Investigation 1. Immediacy: Alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of patient/resident property, will be investigated immediately.