

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper			STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St , Casper, Wyoming, 82601	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 4/21/26 through 4/23/26. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide	F0656	Complaint Survey April 23, 2026 F0656 #1 Community Member #6 PROBLEM STATEMENT: Based on Medical record review and staff interviews, it is alleged that the facility failed to implement resident centered care plans for identified Community Member #6 who had a Care Plan that reflected "Cares in Pairs", however; it was identified that an incident occurred where there was only 1 staff member present during cares. Community Member #6 has discharged to another SNF to be closer to family, on March 13, 2026. Nursing staff has been educated that all identified Community Members will have 2 employees present in the identified individualized intervention for appropriate Community Members room. Corrective Action: While Community Member #6 did discharge from this facility to be closer to family, on March 13, 2026. The investigation had identified that the Care Plan had not been followed and a corrective action and education regarding implementing all Care Plan	06/07/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper			STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St , Casper, Wyoming, 82601	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	<p>Continued from page 1 as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review and staff interview, the facility failed to implement resident centered care plans for 2 of 5 sample residents (#6, #9) reviewed for development and implementation of care plans. The findings were:</p> <p>1. Review of the quarterly MDS assessment dated 3/9/26 showed resident #6 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included non-Alzheimer's dementia, debility, depression, adjustment disorder with mixed anxiety and depressed mood. Further review of the 5/30/24 care plan showed the resident was to receive care with a minimum of 2 staff members present while providing care. The following concerns were identified:</p> <p>Review of an incident report dated 8/16/25 showed CNA #1 provided cares for resident #6 without another staff member present.</p> <p>Interview with CNA #1 on 4/21/26 at 3:40 PM confirmed cares were provided to the resident without another staff member present.</p> <p>Interview with RN #1 on 4/22/26 at 5:26 PM revealed staff had often provided cares to residents who were</p>	F0656	<p>Continued from page 1 approaches that was presented, to the identified employee</p> <p>IDENTIFICATION OF OTHERS:</p> <p>LCCC: DON/Social Services/Designee will conduct an Audit for identified Community Members needing the individualized intervention of "Cares in Pairs" for this alleged deficient practice, to include; review for continued appropriateness of the "Cares in Pairs" individualized approach, compliance with utilizing 2 employees during interactions.</p> <p>SYSTEMIC MEASURES:</p> <p>Based on the comprehensive assessment of the Community Members and consistent with the community member's needs and choices, all LCCC staff will receive Continuing education related to the topics of focus, via hand out material and employee meetings presented by SDC/Designee: Responsibilities for Individualized Interventions, "CARES IN PAIRS" individualized intervention, with a Staff Education Quiz. New Hires will be educated during the orientation process on the facility's policy regarding "Cares in Pairs" and will review included Individualized interventions reviewed following MDS schedule. DON/Social Services/Designee will perform review Monday-Friday via review of Clinical Dashboard for identified "Cares in Pairs" notes. Social Services/Designee will oversee the IDT process in determining targeted "Cares in Pairs", person-centered interventions and IDT will discuss and implement any new identified "Cares in Pairs" with Care Plan being updated to reflect new interventions.</p> <p>CONTINUED MONITORING/SURVEILANCE:</p> <p>DON/Designee will Audit/Review 2 Community Members who have the identified individualized intervention of "Cares in Pairs" weekly x 4 weeks, then Monthly x 90 days or until compliance is achieved. The Plan of Correction will be reviewed in QAPI x 3 months or until compliance is achieved. Continued monitoring by DON/Social Services/Designee will perform review of Clinical Dashboard for behavioral notes, and discussed findings during Grand Rounds with IDT/Social Services/Designee overseeing the process in determining "Care in Pairs" compliance, even after compliance has been meet.</p> <p>Continued F0656</p>	06/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026	
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper		STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St , Casper, Wyoming, 82601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	<p>Continued from page 2 "pairs in cares" without a second staff member present.</p> <p>Interview with the DON on 4/22/26 at 4:50 PM revealed staff were expected to follow resident care plans, including pairs in cares.</p> <p>2. Review of the 3/25/26 quarterly MDS showed resident #9 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia and muscle weakness. Further review of the 3/25/26 care plan showed resident #9 was at risk for malnutrition and had interventions which included monthly, weekly, or as needed weights. The following concerns were identified:</p> <p>Review of the residents weights showed s/he was weighed at a minimum of once a month until 3/13/26. Further review showed there were no documented weights between 3/13/26 and 4/22/26.</p> <p>Review of the 4/10/26 dietician note showed "...No monthly or weekly weight obtained due to scale broken. Will continue to request weekly and monthly weights as needed..."</p> <p>Interview with the dietician on 4/23/26 at 10:16 AM confirmed the resident wasn't weighed.</p> <p>Interview with the DON on 4/23/26 at 10:30 confirmed there was a broken scale; however, staff were expected to use the other facility scale and follow the residents care plan to the best of their abilities.</p> <p>Review of the document titled "Weight monitoring, long term care" last revised 9/15/25 showed "...Weighing a patient in a long-term care facility is an important part of assessing a residents health, following a routine weighing schedule helps detect weight changes. Unless otherwise specified, record a resident's weight at the time of admission, weekly for 4 weeks, and then monthly..."</p> <p>3. Review of the policy titled "Person Centered Care Planning" last revised 8/29/25 showed "...Each resident will have a person-centered care plan developed and implemented to meet...and address the resident's medical, physical, mental and psychosocial needs."</p>	F0656	<p>Continued from page 2</p> <p>#2 COMMUNITY MEMBER #9</p> <p>PROBLEM STATEMENT:</p> <p>Community Members #9 was identified as s/he having a Care Plan identifying as "At Risk for Malnutrition" with interventions, including; Monthly, weekly, and/or "as needed" weights. Where Community Member #9 had been weighed at a minimum of monthly until March 13, 2026, and there were no documented weights between 3/13/26 and 4/22/26.</p> <p>Corrective Actions:</p> <p>To Address alleged Deficiency for Community Member #9 included, obtained weights on April 24, 2026, May 4, 2026, and May 8, 2026, with assessments identified in Nutritional/Dietary Notes on April 24, 2026, May 5, 2026, and May 12, 2026.</p> <p>IDENTIFICATION OF OTHERS:</p> <p>Community Members requiring Nutritional Focus Care Plan approaches that can be identified as "At risk for Nutritional Malnutrition" will have DON/Dietician/Designee complete an Audit for last weight obtained, ensure an order has been identified to obtain Community Member's weight is present and/or corrected to reflect a monthly documentation in the TAR's, and Audit of Community Members Care Plans with a Nutritional Focus and appropriate interventions are present.</p> <p>SYSTEMIC MEASURES:</p> <p>DON/DESIGNEE will ensure all Nursing Staff receive focused education on the topics: Weight Monitoring Purpose, Weight Monitoring Schedule with a review of LCCC facility policy, CNA Responsibilities for Weight Monitoring to include; reporting parameters, Nurse Responsibilities for Weight Monitoring, Nurse manager Responsibilities, LCCC has received a new scale for obtaining Community Member's weights, and provided additional education to the location and instruction in the use of the Hoyer weight scale and the appropriate sling. As an ongoing system, New Hires will be educated during the orientation process on the facility's policy regarding Weight Monitoring.</p> <p>CONTINUED MONITORING:</p> <p>DON/Designee will Audit 5 Community Members</p>	06/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Casper			STREET ADDRESS, CITY, STATE, ZIP CODE 4041 South Poplar St , Casper, Wyoming, 82601	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D		F0656	Continued from page 3 identified during Resident's At-Risk Nutritional meeting to ensure that there are recent weights available and any weight loss identified has been addressed by the IDT weekly x 4 weeks, then Monthly x 90 days or until compliance is achieved. The Plan of Correction will be reviewed in QAPI x 3 months or until compliance is achieved. DON/Dietician/Designee will continue to ensure weights are obtained per facility protocol, to reflect appropriate weight observations, which are captured in Nutritional/Dietary Notes during review in weekly IDT Meeting for identified "Residents at Risk".	06/07/2026