STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , 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 on 7/7/26 through 7/8/26. The survey was prompted by complaint intakes 2607994, 3018077, 3017936, and 3033759. 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 Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure call lights were accessible for 2 of 4 sample residents (#1, #2) reviewed for call lights within reach. The findings were: 1. Review of the care plan initiated on 2/25/26 and revised on 3/27/26 showed resident #1 was at risk for falls related to impaired mobility and weakness, with interventions which included "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The	F0558	F0558- Reasonable Accommodations Needs/Preferences This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules or civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or	07/27/2026

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

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F0558 SS = D	Continued from page 1 resident needs prompt response to all requests for assistance." Further review showed the resident had urinary incontinence, with a goal to remain free from skin breakdown due to incontinence. The following concerns were identified: a. Observation on 7/7/26 starting at 11:20 AM on Hall 4 showed resident #1 yelled for help from his/her room. Continued observation showed the resident's call light was not in reach, and the resident yelled out, "I pooped my pants!" At 11:34 AM a laundry aide entered the resident's room with clean laundry and left the room without providing assistance to the resident. The resident continued to intermittently yell for help. At 12:30 PM a CNA entered the room with the resident's lunch tray, stated "Oh my," exited the room without leaving the lunch tray, and retrieved a second CNA to assist the resident. 2. Review of the care plan initiated on 7/4/26 and last revised on 4/29/26 showed resident #2 was at a risk for falls related to impaired mobility, devices attached to the resident, and anti-anxiety medication, with interventions which included "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." The following concerns were identified: a. Observation on 7/7/26 starting at 11:28 AM showed resident #2 sat in a wheelchair with his/her call light activated. An unidentified staff member entered the room, stated, "I told nursing" and exited the room without turning off the call light. The call light remained on for 22 minutes before 2 CNAs entered the room with a mechanical lift. Observation on 7/7/26 at 12:25 PM showed the resident had been transferred to bed, and his/her call light was on the bedside table and out of reach. b. Interview with resident on 7/7/26 at 12:25 PM revealed s/he had waited an hour and a half for staff to initially respond to the call light, and then s/he was unable to reach the call light after being transferred to bed because it had been left out of reach on the bedside table. 3. Interview with the DON on 7/7/26 at 4:38 PM revealed she expected call lights to be within the	F0558	Continued from page 1 shareholder of the Community of affiliated companies. Corrective Action for Affected Residents: Surveyors reported during a complaint survey on 7/8/2026 that the facility failed to ensure call lights were accessible for 2 of 4 sample residents. Immediately upon identification of the concern, staff were re-educated beginning 7/8/2026 on the importance of ensuring each resident's call light is placed within reach after providing care, repositioning, or prior to leaving the resident's room. Identifying other Residents having the Potential to be Affected: The Director of Nursing (DON) or designee audited resident call lights to confirm they were accessible and within reach of residents who needed them. Any identified concerns were corrected immediately. Measures put into place or Systemic Changes: Nursing Staff have been instructed by DON/designee to verify call light placement as part of every resident interaction and before exiting the resident's room and to answer call lights promptly. The DON or designee reinforced expectations regarding call light accessibility and resident safety during shift huddles and All Staff meeting. Plan to Monitor Performance: The DON or designee will conduct random audits of call light accessibility three times per week for four weeks starting 7/27/26, followed by weekly audits for an additional four weeks. Audit findings will be reviewed by DON/designee through the facility's QAPI process, and additional education or corrective action will be provided as indicated. Date of Compliance: July 27, 2026.	07/27/2026

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F0558 SS = D	Continued from page 2 residents' reach. 4. Review of the policy titled "Call lights: Accessibility and Timely Response" last revised 1/1/26 showed "...5. Staff will ensure the call light is within reach of resident and secured, as needed...6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room..."	F0558		07/27/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview,	F0583	DISCLAIMER This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiencies existed or that the statements made by the survey agency are accurate. This Plan of Correction is submitted solely to comply with the requirements of participation and to demonstrate the facility's commitment to providing quality resident care. The facility reserves the right to dispute the findings through the appropriate processes. The alleged date of compliance is August 15, 2026. F583 – Personal Privacy/Confidentiality of Resident Records 42 CFR §483.10(h)(1)-(3) and §483.10(g)(2) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Any resident identified as being affected by the deficient practice was immediately assessed to determine whether a breach of privacy or confidentiality occurred. Appropriate notifications were completed as required by facility policy and applicable regulations. Any resident information that was improperly disclosed or accessible was immediately secured, and corrective action was taken to prevent any further unauthorized disclosure. The resident and/or responsible party were notified as appropriate. How the facility will identify other residents having the potential to be affected by the same deficient	08/04/2026

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F0583 SS = D	Continued from page 3 medical records request log review, and policy review, the facility failed to ensure the right to secure and confidential medical records in 1 of 3 sample residents (#4) reviewed. The findings were: 1. Review of of the medical records request log showed medical records had been requested for resident #3 on 2/2/26. Review of a progress note dated 5/11/26 and timed 1:57 PM showed resident #3's representative had been notified of missing documentation from the medical record request, and picked up copies of all documents from the request on 5/11/26. The following concerns were identified: a. Review of the medical records that had been received by the resident's representative showed the request included medical records from resident #4. b. Interview with the medical records director on 7/8/26 at 9:57 AM revealed she had been unaware resident #4 records had been included in the request with resident #3. Further interview revealed "I guess they could have been there." 2. Review of the facility policy titled "Authorization for Release of Protected Health Information (PHI)" last updated 4/2026 showed "...Purpose To ensure:...Protection of resident rights and confidentiality..."	F0583	Continued from page 3 practice: All residents have the potential to be affected by this deficient practice. The Executive Director and Health Information/Medical Records completed a review of resident record handling practices, release of information procedures, and confidentiality safeguards to ensure resident information is maintained in accordance with CMS regulations and HIPAA requirements. Current practices regarding record storage, transport, copying, and release of medical information were reviewed for compliance. The Medical Record department has received a dedicated printer to ensure printing without interruptions or additional documents printing at the same time. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has implemented the following systemic changes: Re-educated all department managers and staff on resident privacy rights, HIPAA requirements, confidentiality of protected health information (PHI), and proper release of information procedures. Reinforced that resident information may only be accessed, discussed, copied, or released by authorized individuals for legitimate business or clinical purposes. Reviewed and reinforced the facility's Release of Information Policy and Confidentiality Policy. Implemented additional verification procedures prior to releasing medical records or resident information to ensure the correct resident information is provided to the authorized recipient. Reinforced expectations for secure handling of paper and electronic medical records, including proper storage, transportation, printing, faxing, and disposal of confidential information.	08/04/2026

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F0583 SS = D		F0583	Continued from page 4 New employees will receive education on resident privacy and confidentiality during orientation prior to independently performing job duties. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur: The Executive Director or designee will complete audits of resident record confidentiality and release of information practices. Audits will be completed weekly for four weeks. Audits will be completed monthly for two months thereafter. Audits will verify proper authorization for release of information, correct resident identification, secure handling of confidential information, and staff compliance with confidentiality practices. Any concerns identified during audits will be addressed immediately through corrective action and additional staff education as needed. Audit results will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings monthly for three months. Additional monitoring or corrective action will be implemented if compliance is not sustained. Date of Alleged Compliance: August 4, 2026.	08/04/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure timely incontinence care for 1 out of	F0677	F0677- ADL Care Provided for Dependent Residents This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should	07/27/2026

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F0677 SS = D	Continued from page 5 4 residents (#1) reviewed for ADL care. The findings were: 1. Review of the quarterly MDS assessment dated 5/29/26 showed resident #1 had a BIMS score of 12 out of 15 which, indicated the resident had moderate cognitive impairment, and diagnoses which included heart failure, hypertension, renal insufficiency, renal failure, or end-stage renal disease, chronic obstructive pulmonary disease (COPD) with exacerbation, and aneurysm of the ascending aorta, without rupture. Further review showed the resident required partial to moderate assistance for toilet transfers, and was dependent for toilet hygiene. The following concerns were identified: a. Observation on 7/7/26 starting at 11:20 AM on Hall 4 showed resident #1 yelled for help from his/her room. Continued observation showed the resident's call light was not in reach, and the resident yelled out, "I pooped my pants!" At 11:34 AM a laundry aide entered the resident's room with clean laundry and left the room without providing assistance to the resident. The resident continued to intermittently yell for help. At 12:30 PM a CNA entered the room with the resident's lunch tray, stated "Oh my," exited the room without leaving the lunch tray, and retrieved a second CNA to assist the resident. b. Review of the care plan initiated on 2/25/26 and revised on 3/27/26 showed the resident was at risk for falls related to impaired mobility and weakness, with interventions which included "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Further review showed the resident had urinary incontinence, with a goal to remain free from skin breakdown due to incontinence. 2. Interview with the DON on 7/7/26 at 4:38 PM revealed she expected the CNAs to complete rounds of the residents' rooms, and she expected the call lights to be within reach. 3. Review of the policy titled "Activities of Daily Living (ADLS)" last revised 1/1/26 showed "...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting;..."	F0677	Continued from page 5 be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules or civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. Corrective Action for Affected Residents: During a complaint survey on 7/8/2026 surveyors noted the facility failed to ensure timely incontinence care for 1 out of 4 Residents reviewed for ADL care. The identified resident was immediately assessed for continence care needs. Staff provided prompt incontinence care and implemented interventions to ensure timely toileting and brief changes according to the residents' care plan. The resident was assessed for any adverse outcomes related to delayed care. Identifying other Residents having the Potential to be Affected: All residents requiring staff assistance with incontine nce care and other ADL services were reviewed to ensure care plans accurately reflected current needs. A facility-wide audit of residents' dependent on staff for toileting and incontinence care was completed to identify any additional concerns. Any issues identified were corrected immediately. Measures put into place or Systemic Changes: Staff received re-education regarding timely incontinence care b y DON/designee, following resident-specific care plans, and documentation/ communication of ADL care needs. Nurse managers will reinforce accountability for timely ADL and incontinence care during shift huddles and at All Staff Meetings. Plan to Monitor Performance:	07/27/2026

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F0677 SS = D		F0677	Continued from page 6 The DON or designee will conduct random audits of timely ADL and incontinence care three times per week for four weeks starting 7/27/26, followed by weekly audits for an additional four weeks. Audit findings will be reviewed through the facility's QAPI process by DON/designee, and additional education or corrective action will be provided as indicated. Date of Compliance: July 27th, 2026	07/27/2026