STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	**475 YELLOW CREEK ROAD EVANSTON, WY 82930**

(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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 3/18/25 to 3/19/25 which was prompted by complaint intake WY00004289. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant MDS: Minimum Data Set NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation report, and staff interview, the facility failed to ensure a safe transfer was provided for 1 of 7 sample residents (#1) reviewed for falls. This failure resulted in actual harm to resident #1 who was unable to keep his/her balance during a transfer. The resident suffered a "comminuted [bone breaks in 3 or	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/07/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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
F 689	Continued From page 1	F 689		

more places usually occurring after a forceful event] fracture involving the distal femoral diametaphysis above the femoral component of the left knee prosthesis." The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 3/7/25. The findings were:

1. Review of the 2/14/25 quarterly MDS assessment showed resident #1 had a BIMS score of 8 out of 15 (moderate cognitive impairment); required substantial to maximal assistance with all mobility ADLs; and had diagnoses which included Alzheimer's disease and bipolar disease. Review of the resident's care plan showed the resident had a fall on 3/7/23 and 2 staff were to assist the resident with transfers. Review of the Occupational Therapy Recertification Progress Report and Updated Therapy Plan Report for the certification period of 1/28/25 to 2/26/25 showed the resident required maximal assistance with toilet transfers. The following concerns were identified:

a. Review of a 2/20/25 nurse's note showed resident #1 was "up to the restroom with assistance x [times] 1. Resident lost balance and CNA unable to lower resident to floor. Resident did hit head. Neuros were initiated." Further review of the incident showed the fall occurred at approximately 2:45 PM on 2/20/25. The nursing assessment showed no signs of injury, the resident did not exhibit pain, and had resumed his/her normal activities.

b. Review of a nurse's note, dated 2/21/25 and timed 1:34 AM, showed the resident had started to "yell" and complain of severe pain to his/her knee. The resident was sent for imaging and diagnosed with an "acute nondisplaced oblique spiral type fracture through the distal left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	**475 YELLOW CREEK ROAD EVANSTON, WY 82930**

(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
F 689	Continued From page 2	F 689		

femoral metaphysis superior to the knee arthroplasty." The injury was inoperable and the resident was placed on non-weight bearing status and was prescribed 5 milligrams of oxycodone every 4 hours as needed, 1000 milligrams of Tylenol 3 times per day, and a lidocaine patch to the knee.

c. Review of a 2/24/25 nurse's note showed "Notified physician of resident discomfort/pain. Order received to increase from 5 milligrams to 10 milligrams oxycodone" every 4 hours as needed.

2. Interview with the NHA on 3/19/25 at 9:52 AM confirmed CNA #1 did not follow the resident's care plan which resulted in the resident falling and subsequent injury. The NHA stated the CNA received disciplinary action, had been educated, and audits of the CNA's skills continued to be evaluated. Further, an ad hoc Quality Improvement/Performance Improvement (QAPI) meeting was conducted on 2/27/25.

3. Review of the 2/27/25 QAPI minutes showed falls which occurred on 2/19 and 2/20 were reviewed; education to all staff doing mobility tasks was scheduled; an audit tool was created for the CNA involved; an audit tool was created for all staff doing mobility tasks; and an audit of all care plans for those assessed as needing 2-person assist or were a fall risk was planned.

4. Review of the facility's investigation showed interviews with staff were conducted and it was determined CNA #1 was independently toileting the resident when the resident fell. Education was provided to the CNA, an ongoing audit, which was started on 3/1/25, of the CNA's adherence to care plans and providing safe assistance to residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	**475 YELLOW CREEK ROAD EVANSTON, WY 82930**

(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
F 689	Continued From page 3 was reviewed. An audit of all residents currently listed as a 2-person assist was conducted and education was provided to all staff providing assistance with transfers by the therapy department on 3/7/25.	F 689		