STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Skilled Nursing Community at WLRC	**8204 Wyoming State Highway 789 , Lander, Wyoming, 82520**

(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 recertification survey was conducted by Healthcare Licensing and Surveys from 8/17/26 through 8/21/26. Also reviewed in the course of the survey were complaint intakes #3168222, #3131464, #3168257, #3073405, #3068450, and #3050766. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set PRN: As Needed BIMS: Brief Interview for Mental Status mg: milligram RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/08/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe	F0812	1. Corrective Action for the Affected Staff Member(s) Immediate Correction: Dietary Staff #1, #2 and #3 were immediately provided guidance on the need to wear hair restraints and beard restraints Education provided to the 3 unidentified men(maintenance/operations) about the use of hair restraints and beard restraints 2. Identification of Other At-Risk Residents In-service with kitchen and canteen staff on proper hair restraint usage to be held.	09/25/2026

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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F0812 SS = F	Continued from page 1 growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and 2022 FDA Food Code review, the facility failed to ensure a sanitary environment in 1 of 3 food preparation areas (main kitchen). The census was 20. The findings were: 1. Observation on 8/19/26 at 10:20 AM showed dietary staff member #1 was wearing a hat; however, the staff member had long hair in a ponytail out the back of the hat, which was below his shoulders and was not contained. The observation showed dietary staff member #2 was wearing a hat and had hair coming out the back which was to the staff member's shoulders and was not restrained. In addition, dietary staff member #2 was wearing a beard restraint; however, the staff member had a full mustache which was not covered. Continued observation until 11:02 AM showed the dietary staff members prepared food items for service to residents without restraining their head hair or facial hair appropriately. 2. Observation on 8/19/26 at 10:21 AM showed three unidentified men putting together a table near the meal service steam table. Two of the unidentified individuals had facial hair and were not wearing beard restraints, and none of the individuals were wearing hair restraints. 3. Observation on 8/19/26 at 10:58 AM showed a dietary staff member #3 was wearing a hat with a ponytail out the back and below her shoulder, which was not contained, while preparing food items in the kitchen. 4. Interview with the dietary manager on 8/19/26 at 11:02 AM confirmed staff were to wear hair restraints and the individuals whose hair was not contained under a hat or beard restraint, could contaminate food items.	F0812	Continued from page 1 In-service for auxiliary staff to include all operations staff on hair restraints Audit on hair restraint usage in the service kitchen area to be implemented and conducted by the food service supervisor. In-Service to all CNA/RN/Auxiliary staff working on the cottages. 3. Systemic Changes (Measures to Prevent Recurrence) Laminating signs regarding hair restraints and beard restraints needed in the service kitchen area for all three entrances into the service kitchen. Completed and posted on August 24, 2026. AA05 order placed for 3 compartment holders with lid to hold hairnets, hair bouffants, and beard restraints to post near the hair restraint signs. Three holders requested to provide at all three entrances into the service kitchen. Order received and put up on September 1, 2026. Added to the New Staff Orientation by 9/25/26 4. Monitoring Plan (Quality Assurance / QAPI) Weekly audits for 1 month then monthly audits for 3 months and then quarterly audits Weekly audits started the week of 8/23/2026. Report to QAPI quarterly	09/25/2026

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F0812 SS = F	Continued from page 2 5. Interview with the dietitian on 8/20/26 at 3:35 PM confirmed hair should be restrained in the kitchen and on the cottage when preparing meals. Further she confirmed hair longer than the area covered by a hat, was not contained and could result in contamination of food items. 6. Review of the 2022 FDA Food Code showed "2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	F0812		09/25/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	1. Immediate Corrective Action for Affected Residents Medication Administration & PPE Donning/Doffing (Observations 1, 2, 3, 5): Registered Nurses have been re-educated on the proper sequence and location for donning and doffing Personal Protective Equipment and performing hand hygiene during medication preparation and administration. Re-education emphasized that gloves and gowns must never be worn between medication preparation areas, hallways, or kitchens, and must be doffed with hand hygiene performed prior to leaving the resident's room or moving between distinct tasks. Residents #20, #16, #10, and #13 were assessed for any signs or symptoms of healthcare-associated infections (HAIs). No adverse outcomes or signs of infection were identified Wound Care Practices (Observation 4): Registered Nurse was re-educated on maintaining a sterile/clean field during wound care, including ensuring supply containers, saline bottles, and hands do not touch contaminated surfaces (such as the floor).	09/25/2026

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F0880 SS = F	Continued from page 3 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, infection prevention program review, staff interview, and policy and procedure review, the facility failed to ensure proper donning and doffing of personal protective equipment (PPE) during 5 random observations and failed to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F0880	Continued from page 3 2. Identification of Other Residents Having the Potential to Be Affected All 20 residents residing in the facility have the potential to be affected by improper infection prevention practices and surveillance gaps. A facility-wide audit of current medication administration passes, wound care treatments, and staff PPE compliance was initiated by the Infection Preventionist and Director of Nursing to ensure no additional infection control breaches exist. 3. Systemic Changes & Policy Measures Put in Place Surveillance & Tracking System Implementation: The Infection Preventionist established and operationalized an active, facility-wide Infection Surveillance System. This includes a weekly tracking log for tracking, reporting, investigating, and controlling healthcare-associated infections (HAIs) and communicable diseases for all residents and staff in accordance with §483.80(a)(1) and accepted national standards. PPE & Hand Hygiene Workflow Optimization: Dedicated, covered trash receptacles were verified/installed inside resident rooms near the exit doors to enable proper PPE doffing prior to room exit, aligning with CDC long-term care guidance. Wall-mounted hand sanitizer dispensers and handwashing sinks were audited to ensure full accessibility in medication rooms, resident rooms, and kitchen areas. To be added to new staff orientation by 9/25/26 Glove hangers to be placed in all resident rooms Glove hanger to be hung in readily available spot in	09/25/2026

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F0880 SS = F	Continued from page 4 diseases for all residents. The census was 20. The findings were: 1. Observation of medication administration on 8/18/26 at 11:38 AM showed RN #2 performed hand hygiene and donned a gown and gloves in the medication room, prepared medications, and exited the medication room while wearing the PPE. The RN then walked to resident #20's room, administered medications via G-tube, and exited the room wearing the same PPE. The RN walked down the hallway to the trash can near the kitchen counter, doffed the gown and gloves, disposed of them in the trash, and performed hand hygiene at the kitchen sink. 2. Observation of medication administration on 8/18/26 at 9:32 AM showed RN #3 washed her hands, donned gloves, prepared medications, and exited the medication room while wearing the same gloves. The nurse proceeded to the main kitchen sink, filled a cup with water, and mixed a fiber packet into the water using a spoon. The nurse then entered resident #16's room and administered the oral medications, which the resident swallowed whole with the water, while the nurse wore the same gloves. The nurse exited the room wearing the same gloves, walked to the main kitchen, doffed the gloves, disposed of them in the trash can near the kitchen counter, and performed hand hygiene at the kitchen sink. 3. Observation of medication administration on 8/19/26 at 2:12 PM showed RN #3 performed hand hygiene at the medication room sink and donned gloves. The nurse prepared medications and exited the medication room wearing the same gloves. The nurse then entered resident #10's room and administered the medications, which the resident swallowed whole with water. Prior to exiting the resident's room, the nurse doffed the gloves and performed hand hygiene using hand sanitizer. 4. Observation of wound care on 8/19/26 at 4:38 PM showed RN #3 brought a plastic container of wound care supplies into resident #19's room. The RN donned a gown and gloves in the resident's room, and placed a gloved hand directly on the floor to lower herself to sit in front of the resident's recliner. The RN placed a barrier drape on the floor and set wound care supplies from the container onto the drape. The RN removed the elastic bandage and old dressing from the resident's right lateral and posterior ankle and subsequently changed gloves. The RN cleansed the resident's right ankle wounds with normal saline, applied a non-adherent dressing, and wrapped the right lower extremity (RLE) with	F0880	Continued from page 4 all cottages Policy Review & Revision: The facility's "Standard Operating Procedures Infection Prevention Employee Glove Use," "PPE," and "Infection Prevention and Monitoring Practices" policies were reviewed and re-issued to all clinical staff to ensure alignment with standard and transmission-based precautions. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff, auxiliary and direct care staff will receive in-service training covering: Donning and Doffing PPE: Proper sequence, timing, and requirement to doff gloves/gowns before leaving resident rooms or moving across communal/medication areas Hand Hygiene: Mandatory hand hygiene before donning, after doffing, and after touching any high-touch surface or environment. Aseptic & Clean Wound Care Technique: Proper barrier field setup, keeping supplies off the floor/unsterile surfaces, and glove changes between dirty and clean tasks. Infection Surveillance & Reporting Protocols: Staff responsibilities in reporting early signs/symptoms of communicable disease. 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure sustained compliance, the Infection Preventionist or designated Nursing Supervisor will conduct randomized observational audits: Medication Administration & PPE Audits: 3 observations per week 4 weeks, then 2 observations per week for 4 weeks, then monthly thereafter.	09/25/2026

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F0880 SS = F	Continued from page 5 rolled gauze (Kerlix) and an elastic bandage from the foot to above the knee. The RN then re-wrapped the resident's left lower extremity (LLE) with new rolled gauze and an elastic bandage. Throughout the procedure, a bottle of normal saline and the plastic supply container were observed sitting directly on the floor, off the barrier drape. Following completion of wound care, the RN doffed her gown and gloves and performed hand hygiene at the resident's bathroom sink. 5. Observation of medication administration on 8/20/26 at 8:53 AM showed RN #1 performed hand hygiene at the medication room sink, donned gloves, and pulled medications. While wearing the same gloves, the nurse mixed a powder medication (Miralax) in water, exited the medication room, and retrieved yogurt from the kitchen refrigerator. Still wearing the same gloves, the nurse entered resident #13's room, assisted the resident to sit on the side of the bed, mixed the whole medications into the yogurt, and assisted the resident to take his/her medications. Prior to exiting the resident's room, the nurse doffed her gloves and performed hand hygiene using hand sanitizer. 6. Interview with the infection prevention nurse on 8/21/26 at 8:38 AM revealed her expectation was that staff would doff PPE and perform hand hygiene before leaving the resident's room. 7. Review of the policy and procedure titled "Standard Operating Procedures Infection Prevention Employee Glove Use" and "PPE" showed "Employees are required to wash hands before putting on gloves and again after removing gloves…Anytime an item (book, pitcher, furniture, phone) is touched, the gloves have to be removed, hands re-washed, and then gloves re-applied." Review of the CDC guidelines for long term care titled "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant /Organisms (MDROs)" dated 7/12/22 showed, "Make PPE, including gowns and gloves, available immediately outside of the resident room…Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room." Related to the infection prevention and control program:	F0880	Continued from page 5 Wound Care & Aseptic Technique Audits: 3 wound care procedure observations per week for 4 weeks, then bi-weekly for 8 weeks (if applicable) Infection Surveillance Audits: The IP will review infection surveillance tracking logs weekly to verify timely identification, reporting, and implementation of interventions. Audit results will be compiled and reported to the Quality Assurance and Performance Improvement Committee. The QAPI committee will determine the need for further monitoring or action plans based on compliance thresholds	09/25/2026

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F0880 SS = F	Continued from page 6 1. Review of the infection prevention program showed the facility did not have a system for identifying, reporting, investigating, monitoring infections and communicable diseases for all residents. 2. Interview with the infection preventionist on 8/21/26 at 8:34 AM confirmed the facility did not have a process for monitoring and identifying infections implemented at that time. 3. Review of the policy titled "Infection Prevention and Monitoring-Practices" dated 3/31/22 showed "... The Infection Preventionist or designee shall monitor the effectiveness of our infection prevention and control work practices and protective equipment. This includes, but is not necessarily limited to: a. Surveillance of the workplace to ensure that established infection prevention and control practices are observed and protective clothing and equipment are provided and properly used; b. Investigation of known or suspected exposures to blood/body fluids to establish the conditions surrounding exposure; c. Investigation of known or suspected transmission of healthcare-associated infections; d. Improvement in training, work practices, or protective equipment to prevent reoccurrence of occupational exposures and/or healthcare-associated infections; e. Effective implementation of hand hygiene practices by all departments to prevent the spread of infections; and f. Effective use of disposable gloves and other personal protective equipment to prevent the spread of infection..."	F0880		09/25/2026
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605	1. Immediate Corrective Action for Affected Residents Resident #7 (Deceased): Resident #7 expired prior to the exit of the survey. Because the resident is deceased, individual clinical remediation regarding the Lorazepam PRN order stop date, physician rationale, and target symptom tracking could not be performed for this resident. Resident #13 and Resident #15 (Lack of Target Symptom Monitoring): - The attending physician was contacted to	09/25/2026

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F0605 SS = E	Continued from page 7 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F0605	Continued from page 7 re-evaluate and confirm the specific clinical diagnoses/indications for all prescribed psychotropic medications (aripiprazole, trazodone, quetiapine, clonazepam, bupropion). Specific target symptom behavior tracking logs were implemented on the Google sheet from the nurse manager. for each resident to monitor medication effectiveness and adverse effects. Resident #9 (Gradual Dose Reduction - GDR): The attending physician and consultant pharmacist conducted a clinical review of Resident #9’s psychotropic regimen (olanzapine, haloperidol, sertraline). A Gradual Dose Reduction (GDR) was ordered, or a physician statement detailing specific clinical contraindications/risk-versus-benefit rationale was documented in the medical record. 2. Identification of Other Residents Having the Potential to Be Affected All current residents receiving psychotropic medications (antipsychotics, antidepressants, anti-anxiety agents, hypnotics) have the potential to be affected. All PRN psychotropic orders have a 14-day stop date or documented physician rationale/duration for extension (including residents receiving hospice or palliative care). All psychotropic orders have specific target symptoms identified with active monitoring sheets/logs in place. All residents due for a Gradual Dose Reduction (GDR) have been evaluated, with GDR orders implemented or valid clinical contraindications documented. 3. Systemic Changes & Policy Measures Put in Place	09/25/2026

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F0605 SS = E	Continued from page 8 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure appropriate monitoring was in place for 3 of 5 sample residents (#7, #13, #15), failed to ensure PRN psychotropic medications were limited to 14	F0605	Continued from page 8 Policy Re-Education: The policy "Use and Monitoring of Psychotropic Medications" was reviewed, reaffirmed, and distributed to all licensed nursing staff and prescribing practitioners. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs) and prescribing providers will receive mandatory in-service education regarding: Federal Regulations on Psychotropic Drugs: Requirements under §483.45(e) for 14-day limits on PRN psychotropics (clarifying that hospice residents are not exempt from documentation/rationale requirements). Target Symptom Documentation: Correctly identifying, tracking, and documenting behavior/target symptom severity and frequency prior to and following psychotropic administration. GDR Protocols: Process for acting on pharmacy MRR recommendations and documenting clinical rationale when reductions are contraindicated. 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure ongoing compliance, the Director of Nursing , Clinical Nurse Manager , or designee will conduct the following random audits: PRN & Psychotropic Audits: Audit 100% of new PRN psychotropic orders weekly for 4 weeks, then bi-weekly for 8 weeks, to verify 14-day stop dates, physician rationales, and active target symptom monitoring.	09/25/2026

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F0605 SS = E	Continued from page 9 days or the physician provided a rationale for extended use with a stop date for 1 of 5 sample residents (#7), and failed to ensure a gradual dose reduction was performed for 1 of 5 sample residents (#9) reviewed for unnecessary medications. The findings were: Related to PRN psychotropic medication and appropriate monitoring: 1. Review of the physician orders for resident #7 showed the resident received Lorazepam (anti-anxiety) 0.5 mg by mouth every 4 hours as needed (ordered on 7/17/26). Further review showed no evidence of a physician rationale or stop date indicated and there was no evidence of identified medication specific target symptoms or monitoring for target symptoms. Interview with the DON on 8/20/26 at 8:24 PM revealed she did not think the requirement for a stop date on PRN psychotropic medications included residents on hospice. She confirmed the medication did not have a stop date or identified target symptom monitoring. 2. Review of the physician orders for resident #13 showed the resident received aripiprazole (antipsychotic) 20 mg by mouth daily, trazodone (antidepressant) 150 mg by mouth at bedtime, quetiapine (antipsychotic) 75 mg by mouth at bedtime, and clonazepam (antianxiety) 0.5 mg by mouth at bedtime. Further review showed no evidence of identified medication specific target symptoms or monitoring for target symptoms. Interview with the DON on 8/20/26 at 8:24 PM confirmed there were no identified target symptoms or monitoring. 3. Review of the physician orders for resident #15 showed the resident received bupropion (antidepressant) 150 mg by mouth daily ordered on 1/8/26, clonazepam (antianxiety) 0.5 mg daily ordered on 6/1/26, and aripiprazole (antipsychotic) 20 mg by mouth daily ordered on 6/30/26. Further review showed no evidence of identified medication specific target symptoms or monitoring for target symptoms. Interview with the DON on 8/20/26 at 8:24 PM confirmed there were no identified target symptoms or monitoring. 4. Review of the policy titled "Use and Monitoring of Psychotropic medications" last revised on 4/16/25 showed "...3. Psychotropic Medication Monitoring	F0605		09/25/2026

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F0605 SS = E	Continued from page 10 Plan (Include ISP or BSP) Clearly identify the target symptoms or diagnosis for which the medication is prescribed... Provide clinical justification for medication use, including expected benefits and known risks... Standing orders at SNF may be valid up to fourteen (14) days, unless extended with documentation after an assessment by a licensed medical provider..." Related to gradual dose reduction: 1. Review of the medical record for resident #9 showed the resident received olanzapine (antipsychotic) 30 mg at bedtime ordered on 4/25/25, haloperidol (antipsychotic) 5 mg by mouth twice daily ordered on 4/25/25, and sertraline (antidepressant) 50 mg by mouth daily ordered on 1/7/25. Further review showed a pharmacy recommendation for a gradual dose reduction during the medication regimen review in May 2026 with no specific medication identified; however, there was no evidence a gradual dose reduction or risk versus benefit statement was performed for any of the resident's psychotropic medications. 2. Interview with the DON on 8/20/26 at 8:23 PM confirmed the gradual dose reduction for resident #9 was not performed following the pharmacy recommendation. 3. Review of the policy titled "Use and Monitoring of Psychotropic medications" last revised on 4/16/25 showed "...Psychotropic medication reviews are conducted quarterly and annually during care conferences: Clinical pharmacist and Medical Provider must assess for adverse effects. Prescriber must evaluate tapering potential with data support: Labs, behavioral data, physical findings..."	F0605		09/25/2026
F0689 SS = E	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	F0689	1. Corrective Action for the Affected Resident(s) Nursing Assessment attempted for Resident #7, they refused to allow an assessment. Immediate education provided to them about letting staff know when they are leaving and use of helmets. Nursing assessment attempted on resident #6, they were compliant and allowed an assessment Nursing Assessment attempted on resident #4, due to severity of this situation they were transferred to the hospital for further evaluation	09/25/2026

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F0689 SS = E	Continued from page 11 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, facility incident review, and policy and procedure review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 3 of 3 sample residents (#4, #6, #7) reviewed for accident hazards. The findings were: 1. Review of the comprehensive MDS assessment dated 7/31/26 showed resident #7 had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included dementia, seizure disorder, anxiety, nontraumatic intracerebral hemorrhage, fracture of nasal bones, and restlessness and agitation. The following concerns were identified: a. Review of the facility investigation dated 7/4/26 and timed 6:25 AM showed resident #7 was visualized by staff “walking next to the paintbrush building and turning towards the opal without staff. [resident #7] was dressed in sweatpants and a t-shirt, she did not have her helmet on and temperature was 56 degrees at that time…Security stated [resident #7] reported she was looking for her backpack, they dropped [resident #7] off to her bedroom on Jade at 0634…”. The facility implemented the following corrective actions and interventions following the incident which included, “monitor the resident when out of her room, staff to notify nursing if [resident #7] appears agitated. Staff are to encourage her to wear her helmet…Care plan is updated to increase supervision if [resident #7] exhibits these new behaviors. Two new helmets were ordered to provide alternative options.” Review of the facility investigation report dated 7/31/26 and timed 6:30 AM showed resident #7 was found in the Administration parking lot when the Jade nurse arrived on campus and staff did not know the resident had left the house. The resident was taken back to Jade cottage by another RN who was familiar with the resident. The facility implemented corrective actions and interventions which included, “door alarms were placed on all three doors for notification when staff are busy with other residents…Staff will continue to support [resident #7] and monitor [resident #7] when she is awake.” b. Interview with the nurse manager on 8/19/26 at 2:23 PM revealed the facility didn't lock the doors during the day and they tried to have a staff member	F0689	Continued from page 11 Increased supervision for Resident #6, 7, and 4 Elopement Risk Reassessment was completed on 9/10/2026 The resident’s Care Plan updated to reflect new, active interventions, which include increased supervision for Resident #6, 30 minute checks during waking hours, frequently for times of sleep. Resident #7 passed away on 8/2726, no further interventions Resident #4 is monitored frequently for any SIB behaviors, weekly checking with Social Services Coordinator and In house Provider 2. Identification of Other At-Risk Residents Education provided to all residents at resident council on signing in and out, location of the books on 9-10-2026. Will review at resident council meetings for the next 3 months and then quarterly Signage and books placed at two entrances on both Jade and Sunflower cottages. 3. Systemic Changes (Measures to Prevent Recurrence) Alarms removed from Jade cottage on 9/2026, wander guard to be used if any need arises. #7 and #19 Both have passed Alarms to be set at 2 main doors at all times on the Sunflower Cottage. In-service to all CNA/RN/Aux. staff on the Jade/Sunflower cottages on alarms at Sunflower and Jade. Sent Suicidal Behavior to the policy review committee on 9/9/2026, to include review of l levels of supervision. 4. Monitoring Plan (Quality Assurance / QAPI)	09/25/2026

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F0689 SS = E	Continued from page 12 in the common area to monitor residents to prevent residents from eloping or wandering out the front door. She revealed resident #19 had a wanderguard on his/her walker that will make an alarm sound if the resident tried to go out the front door. She revealed the wanderguard system doesn't lock the door to prevent resident exit. c. Interview with RN #1 on 8/20/26 at 10:45 AM revealed the facility turned the door alarms on at night or during the day if staff weren't available to be in the common area. She revealed the facility tried to always have a staff member in the common area to supervise residents. d. Observation of Jade cottage on 8/18/26 at 8:44 AM showed there were 3 entry/exit doors. Further observation showed a tab alarm was present on each door, and the front door was unlocked. e. Observation of the common area on 8/20/26 at 9:57 AM showed there were no staff stationed in the common area to supervise residents and "car port door" couldn't be visualized from the common area. f. Observation on 8/19/26 at 3:46 PM showed resident #16 exited the front door of the cottage, when no staff was present in the common area, and the door alarm was not on and did not sound. Staff were unaware that resident #16 exited the cottage. 2. Review of the admission MDS assessment dated 7/13/26 showed resident #6 had a BIMS score of 6 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia. The review showed the resident was independent with transfers and was able to walk 150 feet with supervision or touching assistance. Further review showed the resident was marked for wandering behavior which occurred daily, placed the resident at significant risk of getting to a potentially dangerous place, and significantly intruded on the privacy and activities of others. Review of a facility incident dated 8/5/26 and timed 10:30 AM showed the resident left the Sunflower cottage and was found outside. Further review showed the resident was unattended for "about 1 minute." Further review showed corrective action included door alarms placed on the door exiting the cottage and continued staff support of the resident. Review of a facility incident dated 8/15/26 and timed 3:25 PM showed the resident left the Sunflower cottage and was found at the Aster cottage. Further review showed the resident left while staff were busy with other residents and corrective action included ensuring	F0689	Continued from page 12 In-service to all CNA/RN/Aux. staff on the Jade/Sunflower cottages on signing in and out, location of the books. Will audit weekly for 4 weeks, monthly for 3 months and then quarterly until 9/2027 In-service to all CNA/RN/Aux. staff on the Jade/Sunflower cottages on elopement/wandering Will audit monthly for 3 months and then quarterly until 9/2027 In-service CNA/RN/Aux.staff on the Jade/Sunflower cottages on Supervision/Care Plan updates. Will audit weekly for 4 weeks, monthly for 3 months and then quarterly until 9/2027 Inservice on levels of supervision, to include 1:1, review policy with all CNA.RN/AUX staff on the Jade/Sunflower cottage. Audit to include monthly for 3 months and then quarterly unit 9/2027 In-service on Suicidal Behavior, review policy with all CNA.RN/AUX staff on the Jade/Sunflower cottage. Audit to include monthly for 3 months and then quarterly unit 9/2027. Data to be reviewed at QAPI meetings 1. Immediate Corrective Action for Affected Residents regarding E0900 Wandering and Elopement assessment done on resident #6 on 9/10/2026. Care plan currently in place addressing wandering. Care plan updated 9/10/2026 to include implementation of alarms on the doors. 2. Identification of Other Residents Having the Potential to Be Affected One other resident identified as wanderer E0900 but E1000 does not indicate the wandering places the resident at significant risk of getting to a potentially dangerous place. 3. Systemic Changes & Policy Measures Put in Place MDS coordinator to identify those with Yes to E1000 and proactively include E0900 into this monitoring to	09/25/2026

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F0689 SS = E	Continued from page 13 one staff member was present with the resident when s/he was awake and not in his/her room. The following concerns were identified: a. Observations during the course of the survey showed the door alarms were not in place at any time at the cottage. b. Observation on 8/19/26 at 10:04 AM showed the resident ambulated to the living room area of the cottage and sat in a recliner. No staff were present at that time and the door alarms were not in place on the exit door. c. Interview with the facility investigator on 8/20/26 at 12:42 PM revealed staff were to put the alarms on the doors when they were short staffed. d. Interview with CNA #1 on 8/20/26 at 9:56 AM revealed the resident had gone out of the facility a "couple times" and she has heard it happens at night. She revealed the resident thinks his/her vehicle is outside and s/he wants to go look at the cars. She revealed if someone catches the resident trying to leave, they will take him/her to look at the cars. She revealed she was trying to staff the cottage with 3 staff members and sometimes it was difficult. She revealed the cottage had alarms on the doors and staff were expected to alarm the door if they were going to be busy and could not see resident #6. She was not sure how the implementation of alarms was communicated to staff and revealed she learned from another staff member after being off. Further interview revealed if the alarms were not put in place, there was no way for staff to know if a resident left if they were not in the common area at the time. e. Interview with CNA #2 on 8/20/26 at 4:07 PM revealed the administrator had asked her to get some door alarms following one of the incidents and another staff member did not like the alarms, then verbalized concerns to the administrator. The CNA revealed the administrator sent an email to only use the alarms if they were "absolutely needed." Further interview revealed staff did not receive formal training on when or how to use the alarms. f. Interview with the DON on 8/20/26 at 8:20 PM DON confirmed staff should remain in the common area with resident #6 or ensure door alarms were in place. 3. Review of the quarterly MDS assessment dated 8/12/26 showed resident #4 had a BIMS score of 13	F0689	Continued from page 13 identify those at risk prior to getting to a potentially dangerous place. MDS coordinator or nursing staff to complete wandering/elopement assessment. Policy to be reviewed and possibly revised to include E0900 or replace E1000 with E0900. 4. Staff Re education and Training Plan AAPCN education completed regarding section E by MDS coordinator Implementation of dementia trigger tracker to assist with proactively identifying triggers for behaviors and wandering. 5. Quality Assurance & Monitoring Program (QAPI Integration) MDS Coordinator to audit E1000 and E0900 monthly for 3 months then quarterly until 9/2027 for all MDS assessments	09/25/2026

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F0689 SS = E	Continued from page 14 out of 15, which indicated intact cognition, and diagnoses which included non-Alzheimer's dementia, traumatic brain injury, anxiety disorder, depression, psychotic disorder, and post traumatic stress disorder. Further review showed the resident had other behavioral symptoms not directed toward others, such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds, 1 to 3 days during the look-back period and was independent with activities of daily living. The following concerns were identified: a. Review of a facility incident report dated 5/21/26 showed the resident used fingernail clippers to cut him/herself after repeating statements s/he "will be dead by morning." The incident review showed CNA #2 had been monitoring the resident after the statements until she was called away and monitoring was transitioned to CNA #3. The Incident review showed CNA #2 notified CNA #3 of resident #4's comments to self-harm and to "keep a close eye on [him/her]." The incident review showed when CNA #2 returned, CNA #3 was sitting in the office and reported resident #4 was "good" and had not come out of his/her room. The incident review showed CNA #2 went directly to resident #4's room where she observed the resident attempt to hide something under his/her pillow. Further review showed CNA #2 identified the resident had a "cut mark" on the resident's left arm and the resident provided fingernail clippers s/he used to self-harm. b. Interview with CNA #2 on 8/20/26 at 4:07 PM revealed on 5/21/26 resident #4 was having a "rough day" and made comments s/he intended to self-harm. The CNA revealed she was able to get the resident calmed down before having CNA #3 take over supervision while CNA #2 used the restroom. CNA #2 revealed when she returned to the cottage, CNA #3 was in the office and not supervising resident #4. CNA #2 revealed she went directly to resident #4's room, at which time the resident hid something under his/her pillow, and CNA #2 had scratched his/her arm. CNA #2 revealed resident #4 eventually provided the fingernail clippers to her and the resident was transferred to the hospital. CNA # Kaitlyn revealed she had told CNA #3 she needed to be with the resident or outside his/her room due to the self-harm comments. CNA #2 revealed the resident obtained a "long scratch" which was "not very deep" and had minimal blood "similar to like a cat scratch." Further interview revealed when the resident made self-harm statements, staff were expected to place the resident on 1 to 1 care and	F0689		09/25/2026

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F0689 SS = E	Continued from page 15 his/her plan has been that way for "5 years." c. Interview with CNA #3 on 8/20/26 at 4:02 PM revealed on the day of the incident she was told her go to resident #4's cottage because the resident was a 1 to 1 due to self-harm. She revealed she was not at the cottage when the self-harm occurred, only afterwards. She revealed she did not observe the resident's injury. d. Interview with the DON on 8/20/26 at 8:19 PM revealed she expected staff to keep residents in line of sight following statements of self-harm. 4. Review of the policy titled "Wandering and Elopement" last revised 4/5/22 showed "...3. If MDS 3.0 item E1000 A is checked "Yes" an Elopement Risk assessment will be performed and a care plan updated and revised to ensure safety... 9. Nursing will ensure that resident safety devices/alarms are tested prior to application..." 5. Review of the policy titled "Suicidal Behavior" last revised on 8/13/24 showed "...1. Staff shall report any resident suicidal behavior immediately to the nurse. 2. A staff member will remain within direct line of supervision of the resident at all times until they are dismissed by the nurse, mental health professional, or Medical Provider..."	F0689		09/25/2026
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, infection prevention program review, and policy and procedure review, the facility failed to ensure an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The census was 20. The findings were:	F0881	1.Immediate Corrective Action for Affected Residents Resident #4 (Cephalexin Review): On 08/21/2026, the Infection Preventionist (IP) and Medical Director/attending physician reviewed Resident #4's order for Cephalexin 500 mg QID prescribed for prophylaxis. The order was evaluated for clinical appropriateness, indication, and duration using standard antibiotic stewardship criteria (e.g., McGeer / Loeb criteria). The order was updated with a clear clinical indication, start/stop dates, or discontinued based on physician determination. Resident #4 was assessed for any adverse effects associated with prolonged antibiotic use (e.g., C. difficile, allergic response). No adverse events were noted	09/25/2026

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F0881 SS = E	Continued from page 16 1. Review of the medical record showed resident #4 was ordered cephalexin (antibiotic) 500 mg four times per day on 8/15/26 for prophylaxis. Further review showed no evidence the antibiotic was reviewed for appropriateness. 2. Review of the infection prevention program showed no evidence of an active antibiotic stewardship program. 3. Interview with the infection preventionist on 8/21/26 at 8:34 AM revealed the facility did not have an active antibiotic stewardship program to evaluate antibiotic usage. 4. Review of the policy titled "Antibiotic Stewardship" last revised on 2/13/25 showed "...1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents..."	F0881	Continued from page 16 2. Identification of Other Residents Having the Potential to Be Affected All 20 residents residing in the facility have the potential to be affected by the lack of active antibiotic stewardship monitoring. A 100% baseline audit of all current residents receiving systemic antibiotics (prophylactic, empirical, or targeted) was initiated on 08/22/2026 by the Infection Preventionist (IP) and Consultant Pharmacist. The audit verifies that every active antibiotic order includes: A documented, valid clinical indication/diagnosis. Prescribed dose, route, and specified duration/stop date. Indicated laboratory or diagnostic culture results (if applicable). Documented clinical review ("antibiotic time-out") at 48–72 hours after initiation. 3. Systemic Changes & Policy Measures Put in Place Re-establishment of the Active Antibiotic Stewardship Program (ASP): Following the onboarding of the new Infection Preventionist (IP), the facility's Antibiotic Stewardship Program (ASP) will be fully operationalized under the direction of the IP, Medical Director, and Consultant Pharmacist. The "Antibiotic Stewardship" policy was updated and re-issued to reflect operational monitoring workflows, antibiotic protocols, and mandatory review timelines.	09/25/2026

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F0881 SS = E		F0881	Continued from page 17 Tracking & Monitoring System (Antibiotic Log): The IP implemented a centralized Antibiotic Stewardship Tracking Log to record every resident started on an antibiotic. The log captures start date, medication, indication, culture status, 48–72 hour time-out review, and scheduled stop date. An "Antibiotic Time-Out" workflow was embedded into the Google sheets Electronic Health Record (EHR) / MAR, prompting the clinical team and prescribing provider to evaluate antibiotic necessity and culture results at 48–72 hours. Interdisciplinary Collaboration: Quarterly ASP committee reviews were established, involving the IP, Consultant Pharmacist, Medical Director, and Director of Nursing (DON) to track facility-wide antibiotic utilization trends, prescribing practices, and resistance patterns. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs) and prescribing practitioners will receive mandatory education on the Antibiotic Stewardship Program, covering: Antibiotic Protocols & Indications: Requirements for documenting specific clinical rationale/indications before initiating antibiotics. Monitoring & "Antibiotic Time-Out": Performing and documenting the 48–72 hour antibiotic review. Prophylactic Use Monitoring: Guidelines restricting long-term prophylactic antibiotic use without explicit clinical rationale and frequent re-evaluation 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure sustained compliance following the IP	09/25/2026

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F0881 SS = E		F0881	Continued from page 18 program transition, the Infection Preventionist (IP) or DON will execute the following audit plan: Weekly Antibiotic Audits: Audit 100% of new and active antibiotic orders weekly for 4 weeks, then bi-weekly for 8 weeks, to verify documented indications, 48–72 hour reviews, stop dates, and appropriateness.	09/25/2026
F0567 SS = D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is NOT MET as evidenced by:	F0567	1. Corrective Action for Affected Residents A Facility Incident Report was submitted on June 16, 2026, regarding Resident #10 and Resident #19. An investigation was initiated, resulting in a finding of misconduct against Business Office Staff Member #1. Following a Management Investigation Review Team (MIRT) meeting, the team recommended Administrative leave and disciplinary action, and the matter was forwarded to the Human Resources department for final review. All communications and interactions between the Business Office and residents are currently being monitored by the Social Services Coordinator or a designated representative. Documentation was submitted to the Business Office by the Facility Administrator confirming that the facility was responsible for the payment of Resident #19's eyeglasses and that funds were reimbursed to the resident's account on August 25, 2026. The Skilled Nursing Facility Administrator completed a psychosocial interview with Resident #10, who acknowledged an outstanding balance and approved retaining the funds on account to be applied toward the past-due amount. Moving forward, the resident requested that all financial transactions be approved with assistance from the Social Services Coordinator or the Nursing Home Administrator. 2. Identification of Other At-Risk Residents All operational policies related to the Business Office are currently undergoing a comprehensive review in Cheyenne by the Operations, Policy, Tracking, and Contracts Unit.	09/25/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Skilled Nursing Community at WLRC	**8204 Wyoming State Highway 789 , Lander, Wyoming, 82520**

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F0567 SS = D	Continued from page 19 Based on medical record review, resident and staff interview, facility incident review, and policy and procedure review, the facility failed to ensure residents had the right to manage financial affairs and the right to know in advance, what charges a facility may impose against resident funds for 2 of 17 sample residents (#10, #19) reviewed for resident rights. The findings were: 1. Review of a facility incident report dated 6/16/26 and timed 10:30 AM showed an allegation of misappropriation due to business office staff member #1 paid for obligations she deemed necessary without consent or knowledge of residents or guardians. Further review showed a withdrawal of $5000 was removed from the account of resident #10 to pay his/her bill at the facility and $545 from the account of resident #19 for eye glasses the facility was responsible for. 2. Review of the quarterly MDS assessment dated 6/3/26 showed resident #10 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated intact cognition, and diagnoses which included anxiety disorder, depression, bipolar disorder, post traumatic stress disorder, and visual loss. The following concerns were identified: a. Interview with the resident on 8/20/26 at 3:34 PM confirmed money was removed from his/her account without his/her knowledge. S/he revealed the facility did not have anything in place to allow or restrict money being used without his/her consent prior to the incident. b. Review of a "Resident Trust Account" statement for resident #10 during the period of 12/1/25 through 6/10/26 showed a "withdrawal" in the amount of $5000 on 6/1/26. Further review showed the description was "WLRC Maintenance Fund INV #5926." 3. Interview with facility investigator #1 on 8/19/26 at 5:34 PM revealed her investigation showed business office staff member #1 would only allow resident #10 to use $10,000 on a stable account because the resident owed the facility money. She revealed an additional "$6,000" was removed from the resident's account to pay his/her bill, without the resident's consent. Further interview revealed $800 was removed from resident #19's account to pay for glasses; however, the glasses were supposed to be paid for by the facility. 4. Review of a "Resident Trust Account" statement	F0567	Continued from page 19 As part of a full review of resident accounts, the Social Services Coordinator met individually with all residents to confirm their satisfaction and comfort regarding financial interactions with the Business Office. 3. Systemic Changes (Measures to Prevent Recurrence) All Policies related to the Business Office are currently being reviewed in Cheyenne by the Operations, Policy, Tracking, and Contracts Unit Reviewing all other accounts, the Social Services coordinator met with all residents to ensure they felt comfortable with their financial dealings with the Business Office. The Social Services Coordinator or designee will be present for all interactions with the Business Office; dual signatures will be required for any transactions over $150. As well as an IDT approval to support the transaction. Email to be attached to the form. All residents will be given a copy of the trust statements, and SSC will review with the residents who need assistance. All residents, including those with Guardians, Rep Payee, and/or conservator, will have the same opportunity to be involved in all interactions related to their finances. Currently a PIP on Admission. Updating forms for clear expectations. Residents will need to sign off on all transactions. SSC and BO will coordinate at the time of admission to review and sign all admission documentation and consents. All documentation will be scanned into the eHR. Social Services to work directly with the team to complete processes for Glasses, including IDT approval for amounts over $150. Social Services to be involved with Medicaid and	09/25/2026

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F0567 SS = D	Continued from page 20 for resident #19 during the period of 12/1/25 through 6/10/26 showed a "withdrawal" in the amount of $545 on 5/29/26. Further review showed the description was for "glasses Invoice #110018." 5. Interview with the social worker on 8/20/26 at 8:58 AM revealed resident #10 had "about $40,000" in his/her account and needed to spend the money down. She revealed the facility began looking at how much resident #10 could put in a stable account and how much the resident owed the facility. She revealed resident #10 was his/her own guardian and was able to determine how much money s/he wanted to put where and how much s/he wanted to spend. She was told business office staff member #1 would only allow him/her to put $10,000 in the stable account because of how much the resident owed the facility. She revealed business office staff member #1 told her she would only put $10,000 in the stable account and the social worker needed to go with resident #10 to pull $5000 to pay his/her bill at the facility, which the social worker did not feel comfortable doing. She revealed when the resident's account statement arrived, she reviewed it with resident #10 and saw business office staff member #1 had withdrawn $5000, without resident #10's knowledge, to pay his/her facility bill. She revealed resident #10 was upset when s/he learned about the money that was removed, s/he had not agreed to pay the $5000, and the money was not returned to the resident. She revealed resident #10 requested s/he sign for all future withdrawals from his/her account. She revealed after the money was removed, resident #10 became very concerned about his/her money and whether s/he would have enough money. Further interview revealed the business office billed resident # 19 for glasses that the facility should have paid for because nursing staff lost them, which prevented the resident from getting new shoes due to a lack of money in the resident's account. 6. Interview with business office staff member #1 on 8/20/26 at 11:46 AM revealed when resident #10 admitted to the facility, they attempted to get different options in place, such as a stable account, process for paying bills, and getting to a qualifying resource amount. She revealed she attempted to coordinate with the social worker and CNA #1 to attain a resolution on outstanding bills for resident #10; however, resolution did not occur. She revealed at the time of admission resident #10 agreed to pay $5000, which was the amount the resident was comfortable and agreeable to pay, toward his/her bill at the facility. She revealed the resident did not sign anything to demonstrate s/he agreed with the amount and there was not another staff member	F0567	Continued from page 20 STABLE account setup, and assist residents with the application process. Spreadsheet to be set up and shared with the Business Office. All communications from Vendors need to be uploaded to eHR SSC will establish rapport with Guardians by gathering required documentation, consents, and signatures. SSC and BO will meet bi-weekly to review all documentation and collaborate to ensure all items are completed. All communication will be documented in the eHR. The Social Services Coordinator (SSC) or designated representative will be present for all financial interactions with the Business Office. Dual signatures and Interdisciplinary Team (IDT) approval will be mandatory for any personal fund expenditure or transaction exceeding $150, with supporting email authorization attached directly to the transaction record. All residents will receive routine individual account trust statements to maintain complete financial transparency. The SSC will review these statements directly with residents who require cognitive or communication assistance. All residents—including those assigned a Legal Guardian, Representative Payee, or Conservator—will be given full opportunity and encouragement to participate in decisions and interactions regarding their personal finances. The facility is actively implementing a Performance Improvement Plan (PIP) focused on admission workflows and on updating forms to establish clear operational expectations. Residents must sign off on all personal transactions. The SSC and Business Office will collaborate during the admission process to review and obtain signatures on all required financial documentation and consents, and to scan all completed paperwork into the Electronic Health Record (eHR). Social Services will work directly with the interdisciplinary team to manage procurement processes for resident glasses, ensuring explicit IDT approval for any expenses exceeding $150.	09/25/2026

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F0567 SS = D	Continued from page 21 present during the conversation. She confirmed she later removed money from the resident's account to pay his/her facility bill, and she did not notify the resident and the resident did not give permission to remove the funds prior to the withdrawal. The business office staff member revealed resident #19 did not have money removed from his/her account to pay for glasses and she was not aware the facility was responsible for payment. She revealed there was a form that must be completed when the facility was responsible for a payment, and the business office did not receive that form prior to payment for the resident's glasses. 7. Interview with the business office manager on 8/20/26 at 11 AM revealed resident #10 was his/her own guardian and s/he gets very anxious about his/her money. She confirmed the business office didn't have anything signed by the resident to make withdrawals from his/her account. She revealed upon admission, it was agreed resident #10 would pay $5000 per week until s/he was eligible for Medicaid and the administrator or social worker was to take the resident to withdraw the $5000 to pay the bill. She confirmed it was a verbal conversation and the resident did not sign off on transactions. She revealed the payment for resident #19's glasses were made from the resident's account because residents were responsible for glasses purchases if insurance does not pay, and it was not communicated the facility was responsible for the glasses. 8. Review of the policy titled "SNF Resident Personal Funds" last revised 5/16/25 showed "...2. Residents will be encouraged and assisted in managing their financial affairs to the fullest extent possible... Resident accounts will be debited for state-paid, vendor-invoiced approved purchases only after the resident receives all items and the business office receives the corresponding invoices..."	F0567	Continued from page 21 Social Services will assist residents through the application and setup process for Medicaid and STABLE accounts. A centralized tracking spreadsheet will be maintained and shared with the Business Office, and all vendor communications will be routinely uploaded to the eHR. The SSC will maintain ongoing rapport with resident Guardians to systematically gather all required documentation, legal consents, and signatures. The SSC and Business Office will conduct bi-weekly oversight meetings to review documentation, verify compliance, and document all communications in the resident's eHR. Staff In service on Resident Rights to be completed by 9/25/26, expectations of all staff to treat all residents with dignity and respect Resident Rights education provided during monthly resident council meetings, as well as visual aides in all cottages. 4. Monitoring Plan (Quality Assurance / QAPI) Financial trust and transaction audits will be conducted twice per month for the first 2 months, monthly for the following 3 months, and quarterly thereafter to ensure sustained systemic compliance. Audit results, compliance trends, and identified variances will be formally presented at the Quality Assurance and Performance Improvement (QAPI) committee meetings	09/25/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F0578	1. Immediate Corrective Action for Affected Residents Resident #18: The Social Services Coordinator(SSC) resolved the conflicting care plan and physician orders. The outdated 2020 care plan entry referencing "NO CPR/WY POLST/DNR" was removed and reconciled with the active physician order for Full Code.	09/25/2026

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F0578 SS = D	Continued from page 22 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents' right to formulate an advanced directive for 2 of 16 sample residents (#18 and #20) reviewed for advanced directives. The findings were: 1. Review of the comprehensive MDS assessment dated 8/5/26 showed resident #18 had a BIMS score of 99 and assessment for mental status showed short and long term memory problems, with diagnoses which included anxiety, depression, psychotic disorder and post traumatic stress disorder (PTSD). Review of the medical record showed the resident had no Provider's Orders for Life Sustaining Treatment (POLST) form, and she had a legal guardian. Review of the resident's physician orders dated 10/25/23 showed the resident had an order for "Full Code". Review of the resident's care plan dated 9/24/20 showed "NO	F0578	Continued from page 22 On September 9, 2026 the NA sent the Wyoming Provider Orders for Life-Sustaining Treatment (POLST) packet, educational materials regarding advance directives, and a return-receipt request directly to Resident #18's legal guardian. Certified mail sent on 9/10/26 tracking/delivery confirmation and outreach documentation were placed in the resident's medical record. Resident #20: On August 26, 2026, the NA contacted Resident #20's legal guardian to present and discuss advance directive options and the Wyoming POLST form. The POLST packet was officially transmitted to the guardian with documented proof of mailing placed in the medical record. Resident #20 (cognitively intact, BIMS 15) was provided written information regarding advance directives and state law directly, with discussions documented in the clinical record. The order and care plan remain Full Code pending guardian return/execution of the POLST form. Certified mail sent on 9/10/26 tracking/delivery confirmation and outreach documentation were placed in the resident's medical record. 2. Identification of Other Residents Having the Potential to Be Affected All current residents, particularly those with legal guardians or missing POLST documentation, have the potential to be affected. A 100% audit of all current resident records was initiated on 9/11/26 by the Social Services Coordinator(SSC) and Director of Nursing (DON) to ensure: Active physician orders for code status (Full Code vs. DNR) perfectly align with care plans, EHR clinical flags, and signed POLST/Advance Directive forms.	09/25/2026

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F0578 SS = D	Continued from page 23 CPR/WYOPOLST 09/24/2020 - [resident #18] has a DNR which means that CPR is not to be performed if found not breathing and/or without a pulse. Order is in effect only if the client is found not breathing and/or without a pulse." a. Interview with the administrator on 8/19/26 at 12:07 PM revealed the facility had been waiting on resident #18's guardian to fill out, sign, and return the "Provider's Orders for Life Sustaining Treatment (POLST)" form to the facility since the resident was admitted on 8/22/23. The administrator revealed the resident was a full code, and the facility did not have evidence the form was sent to the guardian. 2. Review of the comprehensive MDS assessment dated 6/5/26 showed resident #20 had a BIMS score of 15 indicating s/he was cognitively intact, and diagnoses which included cerebral palsy, epilepsy, and anxiety. Further review of the medical record showed the resident had a legal guardian, an order for "full code", and no POLST form. The following concerns were identified: a. Interview with the administrator on 8/19/26 at 12:07 PM revealed the facility had been waiting on resident #20's guardian to fill out, sign, and return the "Provider's Orders for Life Sustaining Treatment (POLST)" form to the facility since the resident was admitted on 6/11/25. The administrator revealed the resident was a full code, and the facility did not have evidence the form was sent to the guardian . 3. Review of the Policy and Procedure titled "Advance Directives and Code Status (CPR/DNR) with approval date of 9/24/24 showed "1. Prior to or upon admission, the resident and/or their legal representative will be consulted and encouraged to provide or complete a Wyoming Providers Orders for Life Sustaining Treatment (POLST) form, which specifies their wishes for Cardiopulmonary Resuscitation (CPR), Do-Not-Resuscitate (DNR), and other medical interventions. 2. If the resident and/or their legal representative are not willing or unable to formulate a POLST form, the resident shall be considered a "full code" until their specific preference is decided."	F0578	Continued from page 23 Documented evidence exists showing POLST/Advance Directive packets were sent to legal representatives/guardians when not completed upon admission. No conflicting code status documentation exists anywhere in the resident's record. 3. Systemic Changes & Policy Measures Put in Place Tracking & Follow-Up Protocol for Guardians: Social Services established a Legal Guardian & Advance Directive Tracking Log. If a signed POLST or Advance Directive is not returned at admission, automated follow-up intervals are scheduled at 7 days, 14 days, and 30 days post-admission. All communications, mailed packets, phone calls, and certified mail receipts must be logged directly into the EHR under Social Services progress notes. 4. Monitoring Plan (Quality Assurance / QAPI) MDS RN to review on all quarterly MDS, if review is needed they will email the provider. Audit data presented to QAPI	09/25/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F0600	1. Corrective Action for the Affected Residents Immediate Separation & Safety: Resident #5 and Resident #6 were immediately separated at the time of the altercation on [8/17/26 RN assessed both residents for any immediate physical injuries or signs of emotional distress.	09/25/2026

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F0600 SS = D	Continued from page 24 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, facility incident report review, facility investigation review, staff interview, resident grievance review, and policy review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 5 sample residents (#6) reviewed for abuse. The findings were: 1. Review of the admission MDS assessment dated 7/13/26 showed resident #6 had a BIMS score of 6 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia. The review showed the resident was independent with transfers and was able to walk 150 feet with supervision or touching assistance. The review showed the resident had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed toward others on 1 to 3 days during the look-back period. Further review showed the resident was marked for wandering behavior which occurred daily, placed the resident at significant risk of getting to a potentially dangerous place, and significantly intruded on the privacy and activities of others. Review of the significant change MDS assessment dated 7/1/26 showed resident #5 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included anxiety disorder. Further review showed the resident had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed toward others on 1 to 3 days during the look-back period. The following concerns were identified: a. Review of a "Resident Incident Reporting Form" dated 8/13/26 and timed 8 PM showed "[Resident #5] came out from room to go in the dining area. other resident [resident #5] yelled and screamed at [him/her], 'you killed children.' [Resident #5] yelled	F0600	Continued from page 24 Medical & Psychological Evaluation: The attending physicians and family members/legal representatives for both residents were notified immediately. Both residents were seen by their primary care physician on 9/9/26. Resident #5 review from Primary Care Physician Bipolar diagnosis effectively managed with current pharmacological regimen; no medication changes indicated. Environmental controls and active staff oversight maintained to address interpersonal dynamics and ensure ongoing safety. Resident #6 review from Primary Care Physician No recurring behavioral patterns identified requiring pharmacological adjustments. The facility implemented safeguards ensuring ongoing resident security, with proper oversight maintained; no further intervention required currently. Care Plan Updates: The care plans for both residents were reviewed and no updates were made Supervision: Increased monitoring was put into effect immediately to ensure the residents do not have unmonitored contact. 2. Identification of Other At-Risk Residents Facility-Wide Review: The Interdisciplinary Team (IDT) conducted a comprehensive review of all residents with a history of wandering, cognitive impairment, or aggressive behaviors to ensure their current behavioral interventions are accurate and effective. To be completed by 9/25/26 Care Plan Audits: Care plans for residents identified as "at risk" for behavioral expressions were audited to confirm that measurable, individualized de-escalation strategies are actively in place. 3. Systemic Changes to Prevent Recurrence	09/25/2026

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F0600 SS = D	Continued from page 25 back 'fuck you' and came closer, then other resident pushed [resident #5]. [Resident #5] said 'don't mess with the Marines and went to [his/her] room." Further review showed there was no incident investigation or "steps taken to prevent recurrence (Actions." b. Review of a "Resident Incident Reporting Form" dated 8/17/26 and timed 7:30 AM showed "Staff reported that [resident #5] came out of [his/her] room, threw [his/her] water bottle at another resident then just started punching and yelling at [him/her] while the other resident was sitting in [his/her] recliner. Staff called a code green and was able to get [resident #5] off the other resident all while [resident #5] then attacking them and yelling at them to take [him/her] to the rec center. Staff got [resident #5] out the door and security and RT then walked with [resident #5]." Further review showed "Description of Resident's Present Health Condition (To include resident orientation per/post incident)" was marked as "Appears to be getting manic just from how [s/he] has been recently and some days worse than others" and "Steps taken to Prevent Recurrence (Actions)" was marked as "To be determined." c. Review of a facility reported incident investigation dated 8/17/26 and timed 7:25 AM showed "[Resident #5] went after [resident #6], hitting [him/her] in the head with a water bottle. [Resident #6] has a lump and bruise on [his/her] head. The "Summary Findings" showed "[Resident #6] was yelling at [resident #5]. [Resident #5] reacted physically towards [resident #6] hitting [him/her] with a water bottle and tackling [him/her] to the ground. Staff separated both residents. [Resident #6] was assessed for injuries and [resident #5] left the cottage to remain at baseline." The review showed the "Corrective Action" was "Residents were separated immediately. [Resident #5] left the cottage to remain at baseline with support from facility staff and [resident #6] was assessed for injuries at baseline with support from cottage staff." Further review showed "Interventions" were "Both residents will be supported through counseling and support by staff when interacting with each other." d. Review of a grievance form dated 8/18/26 showed resident #5 reported "[Resident #6] annoys me rude[sic], [s/he] is a persistant [sic] asshole. If [s/he] hits the ground, I get mad. Go into blackout. Can't control self. Won't stop. I become violent. Better warn [him/her] to leave me alone." Further review showed "Resolution of Grievance/Complaint" was "Ongoing issue between 2 residents. [Resident #5]	F0600	Continued from page 25 Policy sent to Policy Committee on 9/9/26. Mandatory Staff Re-education: to be completed by 9/25/26 Recognizing early signs of behavioral escalation (agitation, pacing, verbal threats). Direct, immediate intervention and safe separation techniques. Mandatory reporting timelines for resident-to-resident altercations under the Abuse Prevention Policy. 4. Quality Assurance & Monitoring Systems Care plans for behavior-prone residents are being followed. Audits will occur weekly for 4 weeks, then monthly for 2 months, and quarterly. QAPI Oversight: The results of these compliance audits will be reported by the DON to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings.	09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026

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F0600 SS = D	Continued from page 26 can't understand the other resident. Other resident more vocal [and] agitated, delusional. [Resident #5] is currently having a manic cycle. Continue to provide support. [Resident #5] is accepting of this." e. Interview with CNA #1 on 8/20/26 at 9:56 AM revealed resident #5 was currently "cycling" and didn't understand dementia. The CNA revealed on 8/17/26 resident #5 got upset and threw his/her water cup at resident #6, then went and hit resident #6 in the head because resident #6 told resident #5 to "shut up." She revealed resident #6 thought resident #5 was talking too loud and resident #5 walks by others with his/her tablet playing music loudly. The CNA revealed resident #5 wouldn't do anything when staff were around; however, s/he remembers the things resident #6 says and attacks him/her when it was unexpected. The CNA revealed both residents disliked noise and loud people. The CNA revealed staff were expected to be out in the common area anytime resident #5 was in the common area and the resident could not be left alone with other residents. She confirmed the resident had previous altercations before the incident on 8/17/26. Further interview revealed staff were not part of IDT meetings and were not asked for suggestions on behaviors. f. Interview with facility investigator #1 on 8/20/26 at 12:42 PM revealed the altercation on 8/17/26 occurred after previous resident to resident altercations between resident #5 and resident #6 and resident #6 said s/he had pain and sustained a bump following being hit in the head by resident #5. 2. Review of the policy titled "Prevention of Resident Abuse, Neglect, and Exploitation" last revised on 11/6/24 showed "...The resident has a right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart... 10. Post-investigation, the WLRC Management Investigation Review Team will review the incident(s) and investigations to determine: a. Why the incident may have occurred; b. How to prevent further incidents; c. How care or services may be improved to protect residents; d. What additional training may be needed to prevent occurrences and how to determine staff competency post-training; and e. Which staff will be responsible for implementing identified corrective actions when the actions will be complete, and who will monitor the plan's effectiveness (i.e., QAPI Performance Improvement Plan may be developed)..."	F0600		09/25/2026

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F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, resident and staff interview, facility incident investigation review, and policy and procedure review, the facility failed to protect the resident's right to be free from misappropriation by a staff member for 1 of 17 sample residents (#10) reviewed for misappropriation. The findings were: 1. Review of the quarterly MDS assessment dated 6/3/26 showed resident #10 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated intact cognition, and diagnoses which included anxiety disorder, depression, bipolar disorder, post traumatic stress disorder, and visual loss. The following concerns were identified: a. Interview with the resident on 8/20/26 at 3:34 PM revealed money was removed from his/her account without his her knowledge. S/he revealed the facility did not have anything in place to allow or restrict money being used without his/her consent prior to the incident. b. Review of a facility incident report dated 6/16/26 and timed 10:30 AM showed an allegation of misappropriation due to business office staff member #1 paying for obligations she deemed necessary without consent or knowledge of residents or guardians. Further review showed and withdrawal of $5000 was removed from the account to of resident #10 to pay his/her bill at the facility. c. Review of a "Resident Trust Account" statement for resident #10 during the period of 12/1/25 through 6/10/26 showed a "withdrawal" in the amount of $5000 on 6/1/26. Further review showed the description was "WLRC Maintenance Fund INV #5926." d. Interview with facility investigator #1 on 8/19/26 at 5:34 PM revealed her investigation showed	F0602	1: Corrective Action for Affected Residents A Facility Incident Report was submitted on June 16, 2026, regarding Resident #10. An investigation was initiated, resulting in a finding of misconduct against Business Office Staff Member #1. Following a Management Investigation Review Team (MIRT) meeting, the team recommended Administrative leave and discipline of employment, and the matter was forwarded to the Human Resources department for final review 2: Identification of Other At-Risk Residents All operational policies related to the Business Office are currently undergoing comprehensive review in Cheyenne by the Operations, Policy, Tracking and Contracts Unit. As part of a full review of resident accounts, the Social Services Coordinator met individually with all residents to confirm their satisfaction and comfort regarding financial interactions with the Business Office. 3: Systemic Policy Changes & Measures The Social Services Coordinator or designee will be present for all interactions with the Business Office, dual signatures will be required for any transactions over $150. As well as an IDT approval to support the transaction. Email to be attached to form. All residents to be given a copy of trust statements, SSC will review with the residents who need assistance. All residents, including ones with Guardians, Rep Payee, and/or conservator will have the same opportunity to be involved in all interactions related to their finances. Currently a PIP on Admission. Updating forms for clear expectations. Residents will need to sign off on all transactions. SSC and BO will collaborate with coordination at time of admission to review and sign all admission documentation and consents.All documentation will be scanned into the eHR.	09/25/2026

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F0602 SS = D	Continued from page 28 business office staff member #1 would only allow resident #10 to use $10,000 on a stable account because the resident owed the facility money. She revealed "$6,000" was removed from the resident's account to pay his/her bill, without the resident's consent. e. Interview with the social worker on 8/20/26 at 8:58 AM revealed resident #10 had "about $40,000" in his/her account and needed to spend the money down. She revealed the facility began looking at how much resident #10 could put in a stable account and how much the resident owed the facility. She revealed resident #10 was his/her own guardian and was able to determine how much money s/he wanted to put where and how much s/he wanted to spend. She was told business office staff member #1 would only allow him/her to put $10,000 in the stable account because of how much the resident owed the facility. She revealed business office staff member #1 told her she would only put $10,000 in the stable account and the social worker needed to go with resident #10 to pull $5000 to pay his/her bill at the facility, which the social worker did not feel comfortable doing. She revealed when the resident's account statement arrived, she reviewed it with resident #10 and saw business office staff member #1 had withdrawn $5000, without resident #10's knowledge, to pay his/her facility bill. She revealed resident #10 was upset when s/he learned about the money that was removed, s/he had not agreed to pay the $5000, and the money was not returned to the resident. She revealed resident #10 requested s/he sign for all future withdrawals from his/her account. She revealed after the money was removed, resident #10 became very concerned about his/her money and whether s/he would have enough money. f. Interview with business office staff member #1 on 8/20/26 at 11:46 AM revealed when resident #10 admitted to the facility, they attempted to get different options in place, such as a stable account, process for paying bills, and getting to a qualifying resource amount. She revealed she attempted to coordinate with the social worker and CNA #1 to attain a resolution on outstanding bills for resident #10; however, resolution did not occur. She revealed at the time of admission resident #10 agreed to pay $5000, which was the amount the resident was comfortable and agreeable to pay, toward his/her bill at the facility. She revealed the resident did not sign anything to demonstrate s/he agreed with the amount and there was not another staff member present during the conversation. She confirmed she later removed money from the resident's account to pay his/her facility bill, and she did not notify the	F0602	Continued from page 28 Social Services to be involved with Medicaid and STABLE accounts set up and assist the residents with the application process. Spreadsheet to be set up and shared with the Business Office. All communications from Vendors need to be uploaded to eHR SSC will establish a rapport with Guardians, including gathering required documentation, consents, and signatures. SSC and BO will meet bi-weekly to review all documentation and collaborate with each other to ensure all items are completed. All communication will be documented in the eHR. The Social Services Coordinator (SSC) or designated representative will be present for all financial interactions with the Business Office. Dual signatures and Interdisciplinary Team (IDT) approval will be mandatory for any personal fund expenditure or transaction exceeding $150, with supporting email authorization attached directly to the transaction record. All residents will receive routine individual account trust statements to maintain complete financial transparency. The SSC will review these statements directly with residents who require cognitive or communication assistance. All residents—including those assigned a Legal Guardian, Representative Payee, or Conservator—will be provided full opportunity and encouragement to participate in decisions and interactions concerning their personal finances. The facility is actively executing a Performance Improvement Plan (PIP) focusing on admission workflows and updating forms to establish clear operational expectations. Residents must sign off on all personal transactions. The SSC and Business Office will collaborate during the admission process to review and obtain signatures for all required financial documentation and consents, with all completed paperwork scanned into the Electronic Health Record (eHR). Social Services will work directly with the	09/25/2026

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F0602 SS = D	Continued from page 29 resident and the resident did not give permission to remove the funds prior to the withdrawal. 2. Interview with the business office manager on 8/20/26 at 11 AM revealed resident #10 was his/her own guardian and s/he gets very anxious about his/her money. She confirmed the business office didn't have anything signed by the resident to make withdrawals from his/her account. She revealed upon admission, it was agreed resident #10 would pay $5000 per week until s/he was eligible for Medicaid and the administrator or social worker was to take the resident to withdraw the $5000 to pay the bill. She confirmed it was a verbal conversation and the resident did not sign off on transactions. 3. Review of the policy titled "Prevention of Resident Abuse, Neglect, and Exploitation" last reviewed on 11/6/24 showed "...The resident has a right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart... 'Misappropriation of resident property' as defined in 42 CFR § 483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent..."	F0602	Continued from page 29 interdisciplinary team to manage procurement processes for resident glasses, ensuring explicit IDT approval for any expenses exceeding $150. Social Services will assist residents through the application and setup process for Medicaid and STABLE accounts. A centralized tracking spreadsheet will be maintained and shared with the Business Office, and all vendor communications will be routinely uploaded to the eHR. The SSC will maintain ongoing rapport with resident Guardians to systematically gather all required documentation, legal consents, and signatures. The SSC and Business Office will conduct bi-weekly oversight meetings to review documentation, verify compliance, and document all communications in the resident's eHR. Staff In service on Resident Rights to be completed by 9/25/26, expectations of all staff to treat all residents with dignity and respect Resident Rights education provided during monthly resident council meetings, as well as visual aides in all cottages. Policy Prevention of Resident Abuse, Neglect, and Exploitation sent to Policy Review committee on 9/9/2026 4. Monitoring Plan (Quality Assurance / QAPI) Financial trust and transaction audits will be conducted twice per month for the first 2 months, monthly for the following 3 months, and quarterly thereafter to ensure sustained systemic compliance. Audit results, compliance trends, and identified variances will be formally presented at the Quality Assurance and Performance Improvement (QAPI) committee meetings	09/25/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F0609	1. Immediate Corrective Action for Affected Residents Social Services completed a Safety Assessment with	09/25/2026

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F0609 SS = D	Continued from page 30 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, facility investigation review, state survey agency incident database review, and policy review, the facility failed to ensure all alleged violations involving abuse, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse for 1 of 5 sample residents (#12) reviewed for abuse reporting. The findings were: 1. Review of an incident investigation related to misappropriation dated 6/16/26 and timed 10:30 AM showed an interview where the activities coordinator alleged business office staff member #1 approached resident #12 and told him/her she needed the resident's debit card to get money to pay his/her bills. The investigation interview showed after the resident said no, s/he went to his/her room crying and would not come out the rest of the day. Review of the incident report showed an interview where CNA #1 alleged business office staff member #1 asked the CNA to interpret to the resident and wanted the CNA to ask the resident to give her the resident's debit card to pay for his/her stay at the	F0609	Continued from page 30 Resident #12, they reported no symptoms of distress or psychosocial effect Provided education to Resident #12, they have the ability to pay their own bills, provide them with their bills and they will request assistance to pay bills if they choose. 2. Identification of Other Residents Having the Potential to Be Affected Safety Interviews completed with all residents to ensure there are no other concerns Angel Rounds completed weekly for all residents 3. Systemic Changes & Policy Measures Put in Place Peer review by Risk Manager to ensure all Incidents will be separated and investigation will be completed separately. Safety Interviews to be completed randomly with all residents to ensure there are no other concerns 4. Staff Re-Education & Training Plan Audits are to be completed on Reporting weekly for one month, monthly for 3 months, and quarterly Education and re-in-service all CNA/RN/AUX staff on timely reporting to be completed by 9/25/26 Reporting to QAPI meetings by NHA	09/25/2026

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F0609 SS = D	Continued from page 31 facility as it was required to be paid for. The CNA alleged the business office staff member said she must receive payment immediately as the resident was behind on payment. The CNA alleged when she told the resident what the business office staff member told her to say, the resident started crying, went to his/her room, and stayed there. 2. Review of an email sent from the social worker on 6/11/26 at 3:07 PM to the facility investigator showed the social worker alleged business office staff member #1 attempted "on several occasions" to take resident #12's debit card from him/her and the resident declined, followed by crying and shaking. 3. Review of an email from CNA #1 on 6/12/26 at 7:03 AM showed the CNA alleged business office staff member #1 asked the CNA to translate for her, to resident #12, because the business office staff member needed access to the resident's funds. The CNA alleged after translating the information to the resident, s/he became tearful, signed the documents, and expressed fear s/he might be evicted if his/her bills were not paid. 4. Interview with facility investigator #1 on 8/19/26 at 5:34 PM revealed during her investigation for misappropriation, she learned resident #12 was upset because business office staff member #1 was "demanding" his/her debit card which caused the resident to be "very upset." 5. Interview with the social worker on 8/20/26 at 8:58 AM revealed business office staff member #1 went to resident #12's cottage "multiple times" and was "bugging" the resident for his/her debit card. The social worker revealed the resident did not want to give the business office staff member his/her debit card and the interaction would cause him/her to get upset. The social worker revealed resident #12 would become "very stressed and cry" following the interactions with the business office staff member. The social worker revealed the facility had a care conference with the resident and s/he asked why the business office staff member wanted his/her card then began tearing up and crying. Further interview revealed the social worker felt the incident was more mismanagement of funds then stated "I guess it is intimidation."	F0609		09/25/2026

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F0609 SS = D	Continued from page 32 6. Review of the state survey agency incident database showed no evidence an allegation of abuse by business office staff member #1 toward resident #12 was reported. 7. Interview with facility investigator #1 on 8/20/26 at 12:42 PM confirmed the allegations during the interviews was a different allegation than what she was originally investigating and should have been reported. She confirmed a new allegation was not reported following the statements during the investigation interviews. 8. Review of the facility policy titled "Prevention of Resident Abuse, Neglect, and Exploitation" last revised on 11/6/24 showed "...Reporting and response... 3. WLRC Investigative Services, Social Worker, or SNF Administrator will report the allegation to the Wyoming Healthcare Licensing and Survey website immediately, but not later than: Two 92) hours after the allegation is made if the events that cause the allegation involve abuse OR result in serious bodily injury..."	F0609		09/25/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, facility investigation review, and policy review, the	F0610	1. Immediate Corrective Action for Affected Residents Social Services completed a Safety Assessment with Resident #12, they reported no symptoms of distress or psychosocial effect Provided education to Resident #12, they have the ability to pay their own bills, provide them with their bills and they will request assistance to pay bills if they choose. 2. Identification of Other Residents Having the Potential to Be Affected Safety Interviews completed with all residents to ensure there are no other concerns Angel Rounds completed weekly for all residents 3. Systemic Changes & Policy Measures Put in Place Peer review by Risk Manager to ensure all Incidents	09/25/2026

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F0610 SS = D	Continued from page 33 facility failed to ensure evidence that all alleged violations were thoroughly investigated for 1 of 5 sample residents (#12) reviewed for abuse reporting. The findings were: 1. Review of an incident investigation related to misappropriation dated 6/16/26 and timed 10:30 AM showed an interview where the activities coordinator alleged business office staff member #1 approached resident #12 and told him/her she needed the resident's debit card to get money to pay his/her bills. The investigation interview showed after the resident said no, s/he went to his/her room crying and would not come out the rest of the day. Review of the incident report showed an interview where CNA #1 alleged business office staff member #1 asked the CNA to interpret to the resident and wanted the CNA to ask the resident to give her the resident's debit card to pay for his/her stay at the facility as it was required to be paid for. The CNA alleged the business office staff member said she must receive payment immediately as the resident was behind on payment. The CNA alleged when she told the resident what the business office staff member told her to say, the resident started crying, went to his/her room, and stayed there. 2. Review of an email sent from the social worker on 6/11/26 at 3:07 PM to the facility investigator showed the social worker alleged business office staff member #1 attempted "on several occasions" to take resident #12's debit card from him/her and the resident declined, followed by crying and shaking. 3. Review of an email from CNA #1 on 6/12/26 at 7:03 AM showed the CNA alleged business office staff member #1 asked the CNA to translate for her, to resident #12, because the business office staff member needed access to the resident's funds. The CNA alleged after translating the information to the resident, s/he became tearful, signed the documents, and expressed fear s/he might be evicted if his/her bills were not paid. 4. Interview with facility investigator #1 on 8/19/26 at 5:34 PM revealed during her investigation for misappropriation, she learned resident #12 was upset because business office staff member #1 was "demanding" his/her debit card which caused the resident to be "very upset."	F0610	Continued from page 33 will be separated and investigation will be completed separately. Safety Interviews to be completed randomly with all residents to ensure there are no other concerns Policy sent to Policy committee, no changes made at this time. 4. Staff Re-Education & Training Plan Audits are to be completed on Reporting weekly for one month, monthly for 3 months, and quarterly Education and re-in-service all CNA/RN/AUX staff on timely reporting to be completed by 9/25/26 Reporting to QAPI meetings by NHA	09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026

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F0610 SS = D	Continued from page 34 5. Interview with the social worker on 8/20/26 at 8:58 AM revealed business office staff member #1 went to resident #12's cottage "multiple times" and was "bugging" the resident for his/her debit card. The social worker revealed the resident did not want to give the business office staff member his/her debit card and the interaction would cause him/her to get upset. The social worker revealed resident #12 would become "very stressed and cry" following the interactions with the business office staff member. The social worker revealed the facility had a care conference with the resident and s/he asked why the business office staff member wanted his/her card then began tearing up and crying. Further interview revealed the social worker felt the incident was more mismanagement of funds then stated "I guess it is intimidation." 6. Interview with facility investigator #1 on 8/20/26 at 12:42 PM confirmed the allegations during the interviews was a different allegation than what she was originally investigating and should have been reported. She confirmed an investigation was not completed following the statements during the misappropriation investigation interviews. 7. Review of the facility policy titled "Prevention of Resident Abuse, Neglect, and Exploitation" last revised on 11/6/24 showed "...Investigation and Protection 1. Should an allegation of potential resident abuse, neglect, exploitation, misappropriation, or suspicious injury of unknown injury be reported, the Facility Administrator or his/her designee will be notified and will initiate an investigation into the allegation..."	F0610		09/25/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify	F0641	1. Immediate Corrective Action for Affected Residents Resident #3 Following up with Gallo (if no return call to verify active diagnosis, I will enter a note in the residents chart that the diagnosis does exist and where it was found, diagnosis will be entered in MyUnity (it currently is not in MyUnity. Resident #14 unable to alter another MDS coordinators assessment Resident #9 unable to alter another MDS coordinators assessment	09/25/2026

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F0641 SS = D	Continued from page 35 that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and MDS 3.0 RAI manual review, the facility failed to ensure MDS assessments accurately reflected the residents' status for 3 of 13 sample residents (#3, #9, #14) reviewed for MDS accuracy. The findings were: 1. Review of the quarterly MDS assessment dated 11/23/25 showed resident #3 had diagnoses which included non-Alzheimer's dementia. Review of the resident's active diagnoses showed no evidence the resident had a diagnosis of dementia. 2. Review of the annual MDS assessment dated 9/12/25 showed resident #14 had diagnoses which included psychotic disorder and schizophrenia. Further review showed the resident was coded as "no" for A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition" and A1510 was not completed. Further review showed by answering no for A1500, the additional questions and A1510, "Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness. Code B, Intellectual Disability: if resident has been diagnosed with intellectual disability/developmental disability. Code C, Other related conditions: if	F0641	Continued from page 35 2. Identification of Other Residents Having the Potential to Be Affected Review of last 2 comprehensive assessments for all residents was reviewed. 5 other comprehensive MDS assessments were identified to have No indicated in A1500 but further review shows MI/DD dx exist in section I. All 5 MDS assessments were in 2025. 3. Systemic Changes & Policy Measures Put in Place MDS coordinator will follow RAI Manual instructions for Section I: Active Diagnosis Discrepancies found in provider documentation regarding diagnosis will be discussed with the provider and updated in current EMR by either the MDS coordinator or the provider. MDS coordinator will follow RAI Manual instructions for Section A1500: Preadmission Screening and Resident Review (PASRR) MDS coordinator will verify that MI/MR diagnosis are on Wyoming Department of Health PASRR Level II ICD-10 MI/MR Diagnosis Code Listing 4. Staff Re education and Training Plan AAPACN MDS 3.0 Essentials 4 Coding sections A and I completed by this MDS coordinator. ICD 10 Coding training education requested for this MDS coordinator. 5. Quality Assurance & Monitoring Program (QAPI Integration) Monthly Audit of comprehensive MDS assessments will be every 3 months then quarterly until September 2027. Audit priority will be A1500, A1510. Monthly Audit of active diagnosis for all MDS will be done for 3 months then quarterly until September 2027. Audit will include diagnosis identification over	09/25/2026

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F0641 SS = D	Continued from page 36 resident has been diagnosed with other related conditions," were skipped. Review of the PASRR Level II review for the resident showed it was completed on 3/3/23. 3. Review of the annual MDS assessment dated 12/17/25 showed resident #9 had diagnoses which included depression and schizophrenia. Further review showed the resident was coded as "no" for A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition" and A1510 was not completed. Review of the PASRR Level II review for the resident showed it was completed on 12/24/24. 4. Interview with the MDS coordinator on 8/19/26 at 11:40 AM confirmed the PASRR coding was incorrect. 5. Interview with RN #1 on 8/21/26 at 9:42 AM confirmed resident #3 did not have a diagnosis of dementia. 6. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual version 1.18.11 last revised October 2023 showed "...A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life • All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). • Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State... Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions... SECTION I: ACTIVE DIAGNOSES Intent: The items in this section are intended to code diseases that have a direct relationship to the	F0641	Continued from page 36 the 60 day look-back period in combination with active diagnosis over the 7 day look back period per the RAI manual. Auditing will be done by the MDS Coordinator	09/25/2026

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F0641 SS = D	Continued from page 37 resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status... Include the primary medical condition coded in item I0020B in items I0100–I8000: Active Diagnoses in the Last 7 Days... ACTIVE DIAGNOSES Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..."	F0641		09/25/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 1 of 1 sample residents (#19) reviewed for wound care. The findings were: 1. Review of the quarterly MDS assessment dated 5/29/26 showed resident #19 had a BIMS score of 2 out of 15, which indicated severe cognitive impairment, and diagnoses which included moderate dementia with other behavioral disturbance, age related osteoporosis, hypertension, chronic venous insufficiency (peripheral), and chronic pain syndrome. The following concerns were identified: a. Review of the physician orders showed the resident had orders for a "skin assessment with weekly charting" dated 6/3/25, "soak right foot in warm water with Epsom salt no more than 20 minutes daily", "Absorbase topical ointment to BLE each shift" dated 8/20/25 and "bilateral lower extremity compression with ace wraps every 8	F0684	1. Immediate Corrective Action for Affected Residents Resident #19 (Deceased): Resident #19 expired prior to the completion of the survey process. Because the resident is deceased, individual clinical remediation, updated wound care treatments, and live EHR wound assessments could not be performed for this resident. 2. Identification of Other Residents Having the Potential to Be Affected All current residents with active wounds, skin breakdown, or specialized treatments (such as compression wraps or topical ointments) have the potential to be affected. A 100% facility-wide skin and wound audit of all current living residents was initiated on 9/10/26 by theNurse Manager and Infection Preventionist (IP) to ensure: Active physician orders for wound care and skin monitoring are present and accurate. Weekly wound measurements, wound bed descriptions, and treatment effectiveness entries are actively recorded in the EHR Wound Module. Care plans accurately reflect current wound treatment regimens and clinical goals.	09/25/2026

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F0684 SS = D	Continued from page 38 hours" dated 10/30/24, "Sequential Compression Device (SCD) two times daily" dated 8/25/25, and "bacitracin 500 unit/gram topical ointment topical two times daily for five days starting 8/16/26…apply to chronic wound of the right lateral foot". Review of the resident's care plan with a goal date of 9/4/26 showed "Impaired Skin Integrity Related to Chronic Right Ankle Vascular Wounds…Documentation will be maintained until end of treatment…Document Wound Care and other interventions. Document wound specifics every shift…Wound care will be administered per order…1) Clean site with soap and water, dry 2) Apply Bacitracin 3) Cover with Non-Adhesive Pad 4) Secure with Kerlix." b. Review of the resident's nursing notes showed there were no measurements of the right lateral foot wound between 5/9/26 and 8/15/26. Further review showed there was no documentation regarding effectiveness of wound care treatments and progression of the wound. c. Observation of wound care on 8/19/26 at 4:38 PM showed the nurse manager #1 removed resident's ace wrap and dressings from the right lateral foot, changed her gloves, cleansed the wound with saline solution, and reapplied clean dressings which included a non-adherent dressing, kerlix, and an ace wrap. Observation of the wound showed the wound bed was covered with white slough. d. Interview with the infection prevention nurse on 8/21/26 at 8:38 AM revealed the facility did not have a wound care nurse and they didn't have anything where they keep track of wounds. Further interview revealed the facility had not been tracking wounds and there was a wound tab in the electronic health record, but the facility hadn't been using it. 2. Review of the Policy titled "Standard Operating Procedures (SOP) Wound Care and Monitoring" with effective date of 3/1/23 showed "Nursing leadership will create a nursing treatment plan for: a. Acute nursing care plan (NCP) defining treatment plan, documentation requirements, and defined assessments for each discipline. B. Wound care and treatment based on provider orders…medication monitoring for effectiveness and/or side effects if applicable. E. Treatment order for wound monitoring to be completed by nursing. f. Treatment order for wound assessment to be completed by appointed SWC [swift wound care] nurses. 7. Nursing will verify orders and complete shift documentation in EHR [electronic health record] on wound care, wound monitoring and resident condition. Nursing will notify providers with any change of condition. 8. SWC	F0684	Continued from page 38 3. Systemic Changes & Policy Measures Put in Place Operationalizing the EHR Wound Care Module: The facility fully operationalized the EHR Wound Management tab/module to centralize all wound tracking, Weekly Wound Assessments (WWA), measurements (length, width, depth, tissue bed type), and clinical progress logs. Designation of Wound Care Oversight & SOP Compliance: A designated licensed Nurse Manager was assigned to serve as the facility's Wound Care Lead under the supervision of the DON to oversee weekly wound tracking and ensure adherence to the "Standard Operating Procedures (SOP) Wound Care and Monitoring" policy. Established a weekly Wound Review Audit Log to verify that all identified wounds receive weekly measurements, evaluations, and physician notifications for non-healing tissue. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff will receive mandatory in-service training on: Standards of Practice for Wound Care & Assessment: Protocol for measuring, assessing, and documenting wound characteristics (including slough, exudate, and tissue types) on a weekly basis EHR Wound Module Navigation: Mandatory use of the EHR Wound tab for all initial assessments, weekly measurement tracking, and shift documentation. Care Plan Alignment & Physician Notification: Reporting non-healing wounds, slough buildup, or lack of progress to the attending provider for prompt treatment re-evaluation.	09/25/2026

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F0684 SS = D	Continued from page 39 nurse will…a. Complete wound assessment with the Swift application per provider orders. B. provide education to support staff and nursing based on progression of wound. C. assist nursing with wound care and monitoring as applicable. D. notify provider with healing progress."	F0684	Continued from page 39 5. Quality Assurance & Monitoring Program (QAPI Integration) To sustain compliance and ensure continuous monitoring of wound care across the facility, the Nurse Manager will execute the following audit schedule: Weekly Wound Documentation Audits: Audit 100% of resident wound records weekly for 4 weeks, then bi-weekly for 8 weeks, to verify weekly measurements, shift documentation, and care plan accuracy.	09/25/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756	1. Immediate Corrective Action for Affected Residents Resident #7 (Deceased): Resident #7 expired prior to the completion of the survey. Individual clinical remediation regarding historical June/July Medication Regimen Reviews (MRR) could not be performed for this resident. Residents #3, #9, #13, and #15: 9/11/26 , the Director of Nursing (DON) and or Nurse Manager conducted an immediate interim clinical chart audit of active medication orders for Residents #3, #9, #13, and #15 to ensure resident safety, confirm no urgent unaddressed drug irregularities or adverse reactions were present, and verify current order accuracy. Resident #9 (Gradual Dose Reduction): The attending physician and DON reviewed the May 2026 pharmacy recommendation regarding a Gradual Dose Reduction (GDR). The physician documented a formal assessment in the medical record addressing the GDR recommendation, including clinical rationale or order adjustment. All active records for Residents #3, #9, #13, and #15 will receive a comprehensive, formal Drug Regimen Review (MRR) by the incoming contracted pharmacy team immediately following contract onboarding. 2. Identification of Other Residents Having the Potential to Be Affected	09/25/2026

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F0756 SS = D	Continued from page 40 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure the medication regimen of each resident was reviewed at least once a month by a licensed pharmacist for 5 of 5 sample residents (#3, #7, #9, #13, #15) reviewed for medication regimen review. The findings were: 1. Review of the medical record for resident #3 showed no evidence a medication regimen review was performed by the pharmacy in June or July. 2. Review of the medical record for resident #7 showed no evidence a medication regimen review was performed by the pharmacy in June or July. 3. Review of the medical record for resident #9 showed no evidence a medication regimen review was performed by the pharmacy in June or July. Further review showed a pharmacy recommendation for a gradual dose reduction during the medication regimen review in May 2026; however, there was no evidence a gradual dose reduction was performed. 4. Review of the medical record for resident #13 showed no evidence a medication regimen review was performed by the pharmacy in June or July. 5. Review of the medical record for resident #15 showed no evidence a medication regimen review was performed by the pharmacy in June. 6. Interview with the DON on 8/20/26 at 8:23 PM confirmed some medication regimen reviews were not performed in June and July; however, she was unsure why. Further interview confirmed the gradual dose reduction for resident #9 was not performed following the pharmacy recommendation.	F0756	Continued from page 40 All 20 residents residing in the facility have the potential to be affected by gaps in monthly consultant pharmacy Drug Regimen Reviews. 9/15/26 , the Director of Nursing (DON) completed a 100% baseline review of all current resident medical records to ensure no unaddressed high-risk medication issues, acute side effects, or pending critical pharmacy recommendations exist. 3. Systemic Changes & Policy Measures Put in Place Contracting with the Wyoming State Hospital Pharmacy Services: To resolve the service gap resulting from the retirement of prior onsite pharmacy staff, the facility initiated a formal transition to utilize consulting pharmacy services from the Wyoming State Hospital Pharmacy. An initial operational and expectations alignment meeting with the Wyoming State Hospital Pharmacy team is scheduled for 09/23/2026 to finalize the contract terms, establish monthly MRR schedules, define reporting workflows, and set urgent irregularity notification protocols. Updated MRR Policy & Standard Operating Procedures The policy "Monthly Drug Regimen Review and Irregularity Reporting" will be updated jointly by 09/25/2026 with the incoming pharmacy team. The updated SOP will define: Mandatory monthly review timeframes and chart access protocols for all facility residents. Written irregularity reporting templates sent directly to the DON, Medical Director, and Attending Physician. A mandatory 14-day timeline for attending	09/25/2026

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F0756 SS = D		F0756	Continued from page 41 physicians to review, act upon, and document clinical rationales/responses in the EHR for all pharmacy recommendations. Steps for urgent/emergent pharmacy notifications requiring immediate physician contact. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs) and attending prescribing providers will receive mandatory in-service training covering: Federal MRR Requirements (§483.45(c)): The statutory requirement for monthly pharmacy reviews and mandatory physician responses/documentation. Pharmacy Recommendation Workflow: Processing incoming pharmacy irregularity reports, logging them in the central tracking system, and transmitting them to attending physicians promptly. Physician Documentation Standards: Ensuring attending physicians document explicit clinical action or rationale in the medical record within 14 days of receiving a pharmacy recommendation. 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure sustained compliance following the pharmacy service transition, the Director of Nursing (DON) or Designee will execute the following audit plan: Monthly MRR Compliance Audits: Audit 100% of resident records monthly for 6 consecutive months to verify that a monthly Drug Regimen Review was completed and signed by the licensed consultant pharmacist.	09/25/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761	1. Immediate Corrective Action for Affected Resident Resident #9 (Lantus SoloStar Insulin Pen):	09/25/2026

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(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
F0761 SS = D	Continued from page 42 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and manufacturer recommendation review, the facility failed to properly label opened multi-dose vials with the opened and discard dates in 1 of 1 medication storage areas (Jade Cottage). The census was 20. The findings were: 1. Observation of the medication storage room in Jade cottage on 8/19/26 at 9:43 AM showed 1 opened Lantus insulin pen for resident #9 in the refrigerator that did not have an opened or discard date. 2. Interview with the nurse manager on 8/19/26 at 9:43 AM revealed she was not aware of a facility policy for dating insulin pens after opening them and stated “they should be dated.” The nurse manager visualized the insulin pen and confirmed there was no open or discard date on the pen. 3. Review of the Lantus manufacturer recommendations for storage last revised on 5/2025 showed “...3 ml single-patient-use SoloStar prefilled pen In-use (opened) [store] 28 days Room temperature only (Do not refrigerate)...”	F0761	Continued from page 42 Replaced pen and labeled correctly Purchased stickers for out of date labeling for RN use and provide in all med rooms 2. Identification of Other Residents Having the Potential to Be Affected All residents requiring insulin or multi-dose biological medications have the potential to be affected by improper dating or storage. 09/15/2026, the Director of Nursing (DON) and Nurse Manager conducted a 100% audit of all medication storage areas (medication carts, medication room refrigerators, and storage cabinets across all cottages) to ensure that: All opened multi-dose vials, insulin pens, eye drops, and biologicals are clearly labeled with the Open Date and calculated Discard Date/Expiration Date. All in-use insulin pens (including Lantus) are stored strictly per manufacturer instructions (e.g., room temperature vs. refrigeration once opened). Any undated, expired, or improperly stored multi-dose medications were immediately removed and destroyed. 3. Systemic Changes & Policy Measures Put in Place Policy & Labeling Standard Operating Procedure (SOP) Revision: The facility policy on "Medication Storage, Multi-Dose Vial & Insulin Pen Labeling" was updated to explicitly specify manufacturer-required open/discard timeframes (e.g., Lantus SoloStar prefilled pens: discard after 28 days; store in-use pens at room temperature only, do not refrigerate after opening). Routine Shift Audits:	09/25/2026

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F0761 SS = D		F0761	Continued from page 43 Implemented a shift-change medication cart and refrigerator audit checklist for licensed nurses to verify proper labeling and storage temperatures prior to medication administration passes. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs) and Nurse Managers will receive mandatory in-service training covering: Labeling Requirements for Multi-Dose Vials & Biologicals: Mandatory requirement to write both the Date Opened and the Discard Date on all multi-dose items immediately upon opening. Manufacturer Storage Guidelines: Specific storage parameters for insulin types, including room-temperature storage restrictions for open Lantus SoloStar pens Disposal Protocols: Identifying and discarding expired, improperly stored, or undated medications immediately. 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure sustained compliance, the Director of Nursing (DON), Nurse Manager, or Designee will conduct the following randomized physical inspections: Medication Storage Audits: Inspect 100% of medication storage areas (refrigerators, carts, and supply rooms across all cottages) 2 times per week for 4 weeks, then weekly for 8 weeks, to verify that all open multi-dose vials/pens have legible open/discard dates and are stored under proper temperature conditions. Consultant Pharmacy Storage Reviews: Following the 09/23/2026 onsite visit, the incoming Consultant Pharmacist from Wyoming State Hospital Pharmacy will conduct monthly medication room and cart audits, submitting findings to the DON.	09/25/2026

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F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical,	F0849	1. Immediate Correction Resident #7 passed away prior to the receipt of the Form CMS-2567. 2. 2.Identification of Other At-Risk Residents The facility has established a systemic protocol to ensure that immediately upon any future hospice admission, the following actions take place: Joint IDT Collaboration: An Interdisciplinary Team (IDT) meeting will be held jointly between the hospice provider and the MVSNC IDT Team within 48 hours of admission to hospice care. Care Plan The resident’s care plan will be comprehensively updated to include all contracted hospice services, specific discipline visit frequencies (Nursing, CNA, Chaplain, Volunteers), and individual preferences. Emergency & Contact Protocols: The updated care plan will specify exactly how and when to contact the hospice provider, outline 24-hour access details, and provide clear triggers for communication regarding changes in condition or immediate medication needs 3. Systemic Changes (Measures to Prevent Recurrence) Policy sent to policy review committee Credentialed Portal Access: To prevent information silos, direct online hospice portal access has been provisioned specifically to the Nurse Manager (NM), Senior RNs, MDS RN, Social Services Coordinator (SSC), and Director of Nursing (DON). EHR Upload Workflow: A mandatory clinical records pipeline has been established. Any documentation or visit note uploaded to the hospice agency's external portal will be systematically pulled, sent to Medical Records, and uploaded directly into the resident's permanent EHR	09/25/2026

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F0849 SS = D	Continued from page 45 mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F0849	Continued from page 45 Staff Communication: The Nurse Manager is designated as the clinical point-of-contact and will directly update and brief the Nursing Department regarding all changes made to a resident's care plan upon hospice enrollment. 4. Monitoring Plan (Quality Assurance / QAPI) The Nurse Manager (or clinical designee) will initiate an audit immediately upon any future hospice admission. Audit Schedule: Completed within 48 hours of a resident's admission to Hospice care. Then once a week for the first month of hospice service. quarterly for the duration of the resident's stay on hospice care.. Reporting: Audit findings will be routed directly to the Quality Assurance Performance Improvement (QAPI) Committee	09/25/2026

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F0849 SS = D	Continued from page 46 §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if	F0849		09/25/2026

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F0849 SS = D	Continued from page 47 any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to implement the hospice agreement for 1 of 1 sample residents (#7) reviewed for hospice services. The findings were: 1. Review of the comprehensive MDS assessment dated 7/31/26 showed resident #7 had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included dementia, seizure disorder, anxiety, nontraumatic intracerebral hemorrhage, fracture of nasal bones, and restlessness and agitation. The following concerns were identified: a. Review of the medical record showed the facility did have a contract for hospice services with a hospice provider for the resident; however, there was no evidence of a collaborative plan of care for hospice service. 2. Interview with the nurse manager on 8/19/26 at 2:23 PM revealed the resident went on hospice services due to a “brain bleed.” 3. Interview with RN #1 on 8/21/26 at 9:39 AM revealed the resident was the first hospice resident the facility had, and the hospice agency had not given nursing any paperwork such as a binder or folder with hospice information. Further interview confirmed nursing had not been coordinating care with hospice and she had “sent an email this week to staff that nursing needs to be updating hospice for coordinating care.” 4. Review of the Policy titled “Hospice” and dated	F0849		09/25/2026

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F0849 SS = D	Continued from page 48 4/1/22 showed "1. WLRC [Wyoming Life Resource Center] and Hospice Services will enter into an agreement in accordance with State and Federal law, which will be signed by an authorized representative of WLRC and Hospice. This agreement will specify services provided by hospice and by WLRC…4. Both the Hospice and WLRC will coordinate the care plan together for seamless care."	F0849		09/25/2026
F0865 SS = D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope.	F0865	1. Immediate Corrective Action for Affected Residents The QAPI Committee will schedule monthly meetings through December 2026 to ensure the Performance Improvement Projects for F600 and F883 measurements are implemented to prevent recurrence of the deficient practices. The QAPI committee and Governing Body members will re-review the facility policy regarding their roles and expectations. 2. Identification of Other Residents Having the Potential to Be Affected An update to the 2026 QAPI Work Plan will reflect the committee adding the PIP's to address the targeted F600 and F883 deficiencies. 3. Systemic Changes & Policy Measures Put in Place A QAPI Governing Body meeting was held on September 16, 2026 to re-educate the QAPI members on their roles and responsibilities. Emphasis was placed on their responsibility to report high-volume, problem-prone areas/metrics, resident altercations, sentinel events, PIPs, and any other concern to the SNF QAPI. This reporting enables the SNF QAPI to perform due diligence in analyzing the problem or recommending a PIP be completed. At the meeting the following actions were taken at the meeting: The Governing Body conducted a quiz. Review of the facility Administrative Management (Governing Body) policy was reviewed with members.	09/25/2026

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F0865 SS = D	Continued from page 49 A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in	F0865	Continued from page 49 A memo detailing Skilled Nursing Care facility Governing Body Responsibilities was reviewed. A copy of the facility PIP template was shared with all members. A Formal memo was written by the Governing Body QAPI to the SNF staff discussing the mandatory reporting for resident to resident altercations which the SNF Administrator will discuss with the SNF staff and post in the Huddle room as a reminder for staff to report.. 4. Staff Re-Education & Training Plan The QAPI committee will add to the monthly agenda other F tag requirements not met during the 8/21/26 survey to monitor whether the measures all other departments are auditing actually confirm data collection and if their reporting mechanisms feed into the QAPI committee confirmed by documentation in the minutes. 5. Quality Assurance & Monitoring Program (QAPI Integration) Monthly QAPI meetings to review all audits put into place for the 8/21/2026 Survey. Review of all data collected, reporting requirements are addressed, and continue throughout the year of 2027.	09/25/2026

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F0865 SS = D	Continued from page 50 systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on facility survey result history review, quality assurance and performance improvement (QAPI) program review, staff interview, and policy and procedure review, the facility failed to implement systems to prevent recurrence of deficient practice at regulations F600 and F883. The facility census was 20. The findings were: 1. Review of the facility survey results history showed the facility was cited for F600 in 2025 and 2026 and was cited for F883 in 2026. 2. Review of the facility policy titled "SNF-Quality Assurance Performance Improvement" dated 10/28/24 showed "...2. The QAPI Plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed..." 3. Review of the quarterly QAPI minutes dated 8/13/26 showed no performance improvement plans (PIPs), and no identified concerns were reported for	F0865		09/25/2026

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F0865 SS = D	Continued from page 51 F600 or F883. 4. Interview with risk management #1 on 8/21/26 at 9:58 AM confirmed the facility had not made good faith efforts to correct deficient practice at F600 or F883 in their QAPI program. Further interview revealed the facility had not had a PIP for either deficiency since the original survey plan of correction.	F0865		09/25/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and	F0883	Immediate Corrective Action for Affected Residents Resident #13 (Pneumococcal Vaccination): On 9/11/26 the Infection Preventionist (IP) and attending provider reviewed Resident #13's immunization history. Educational materials regarding pneumococcal vaccination options (PCV15, PCV20, or PCV21 following the prior 2022 PPSV23 dose per CDC ACIP guidelines) were provided to the resident/legal representative. Vaccine consent/declination documentation was completed. Upon receipt of informed consent, the appropriate pneumococcal vaccine was offered/administered, or a formal refusal/contraindication was recorded in the EHR. Resident #18 (Influenza Vaccination): On 9/11/26, the IP provided vaccine education regarding the risks and benefits of the influenza vaccine to Resident #18's legal guardian. Formal consent/declination was documented. Resident #18 was offered the influenza immunization, and the outcome (administration or signed declination) was recorded in the clinical record. 2. Identification of Other Residents Having the Potential to Be Affected All 20 residents residing in the facility have the potential to be affected by incomplete immunization tracking or missed vaccination offers.	09/25/2026

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(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
F0883 SS = D	Continued from page 52 potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and medical record review, the facility failed to implement policies to offer eligible residents pneumococcal immunization for 1 of 5 sample residents reviewed (#13) and failed to offer 1 of 5 sample residents (#18) the influenza immunization for the 2025/2026 season. The findings were: 1. Review of the medical record for resident #13 showed the resident received the pneumococcal PPSV23 vaccination in 2022 and was eligible to receive the pneumococcal PCV15, PCV20, or PCV21 at least 1 year after the PPSV23 dose. Further review showed no evidence the PCV15, PCV20, or PCV21 was offered, administered, or declined. 2. Review of the medical record for resident #18 showed no evidence the resident was offered, administered, or declined the 2025 influenza vaccination. 3. Interview with the infection preventionist on 8/21/26 10:18 AM confirmed there was no evidence of influenza consent, administration, or declination in 2025 for resident #18. Further interview revealed the provider thought resident #13 was up to date on his/her pneumococcal vaccinations. The Infection preventionist confirmed the resident was not up to date.	F0883	Continued from page 52 On 9/11/26 , the Infection Preventionist (IP) initiated a 100% audit of all resident immunization records to verify: Updated pneumococcal vaccination status according to current CDC/ACIP adult schedules. Documented education, offer, administration, or signed declination for influenza vaccines for the 2025/2026 season. 3. Systemic Changes & Policy Measures Put in Place Immunization Tracking & EHR Integration: The IP operationalized a centralized Immunization Tracking Log embedded in the EHR to record admission status, educational delivery dates, consent/declination statuses, and administration dates for Pneumococcal and Influenza vaccines. A mandatory admission and quarterly immunization review workflow was established within the EHR to prompt the clinical team to check CDC ACIP eligibility upon admission and during routine care plan updates. Policy Review: Re-issued the "Resident Immunizations" policy to ensure explicit guidance on tracking multi-dose or updated pneumococcal schedules (PCV15/20/21) following PPSV23 doses. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs), CNAs, and Auxiliary staff will receive mandatory in-service training on: Federal Vaccine Requirements (§483.80(d)): Requirements for providing education, offering vaccines, and documenting consent/declination in the EHR.	09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026

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Mountain View Skilled Nursing Community at WLRC	**8204 Wyoming State Highway 789 , Lander, Wyoming, 82520**

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F0883 SS = D	Continued from page 53 4. Review of the policy titled "Resident Immunizations" last revised 2/13/25 showed "...All residents will be reviewed for eligibility and offered recommended immunizations per CDC Guidelines unless the following apply: the immunization is medically contraindicated, the resident or legal representative declines immunization, or the resident has already received the immunization..."	F0883	Continued from page 53 CDC/ACIP Adult Immunization Schedules: Correctly evaluating pneumococcal vaccine timing and influenza seasonal offerings. 5. Quality Assurance & Monitoring Program (QAPI Integration) To sustain compliance, the Infection Preventionist (IP) or DON will execute the following audit schedule: Admission & Quarterly Immunization Audits: Audit 100% of new admissions and 20% of quarterly resident chart reviews monthly for 3 months, then quarterly thereafter, to ensure vaccine education, consent, administration, or declination forms are complete.	09/25/2026
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.	F0887	Immediate Corrective Action for Affected Resident Resident #20: On 9/11/2026, the Infection Preventionist (IP) provided written and verbal educational information regarding the benefits, risks, and potential side effects of the COVID-19 vaccine to Resident #20 and their legal guardian. The resident/legal representative was provided the opportunity to accept or decline the COVID-19 vaccination. The resulting decision (consent/declination) was documented in the resident's medical record. 2. Identification of Other Residents Having the Potential to Be Affected All 20 residents residing in the facility have the potential to be affected by unaddressed COVID-19 vaccine offers or missing educational documentation. On 09/10/2026 the IP completed a 100% audit of all current resident medical records to ensure that documented COVID-19 vaccine education, consent, administration, or declination exists for every	09/25/2026

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F0887 SS = D	Continued from page 54 (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and medical record review, the facility failed to implement policies to offer eligible residents COVID immunization for 1 of 5 sample residents reviewed (#20). The findings were: 1. Review of the medical record for resident #20 showed no evidence the resident was offered or educated about the COVID vaccination. 2. Interview with the infection preventionist on 8/21/26 at 10:18 AM confirmed there was no evidence the resident was offered or educated regarding COVID vaccination. 3. Review of the policy titled "Resident Immunizations" last revised 2/13/25 showed "...All	F0887	Continued from page 54 resident. 3. Systemic Changes & Policy Measures Put in Place Centralized Reporting & Tracking: Consolidated resident and staff COVID-19 vaccination statuses into the facility's IP tracking system to align with NHSN/CDC reporting standards. 4. Staff Re-Education & Training Plan By 09/25/2026, 100% of licensed nursing staff (RNs, LPNs) and Social Services staff will receive mandatory in-service education regarding: COVID-19 Vaccine Education & Offer Mandates (§483.80(d)(3)): Requirements to provide Vaccine Information Statements (VIS) or EUA Fact Sheets prior to offering vaccination. EHR Documentation Standards: Properly recording education dates, consent/refusal forms, and administration details in the clinical record. 5. Quality Assurance & Monitoring Program (QAPI Integration) To ensure ongoing compliance, the Infection Preventionist (IP) or DON will execute the following audit plan: COVID-19 Vaccination Audits: Audit 100% of new admissions weekly for 4 weeks, then monthly for 2 quarters, to verify complete documentation of COVID-19 education, vaccine offers, and signed consent/declination forms	09/25/2026

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F0887 SS = D	Continued from page 55 residents will be reviewed for eligibility and offered recommended immunizations per CDC Guidelines unless the following apply: the immunization is medically contraindicated, the resident or legal representative declines immunization, or the resident has already received the immunization..."	F0887		09/25/2026