STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River Rehabilitation and Wellness	1002 Forest Drive Riverton, WY 82501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 16146 Based on medical record review, staff interview, and review of facility investigation and education documentation, the facility failed to ensure residents were free from physical abuse by other residents for 1 of 4 residents (#10) reviewed for allegations of abuse. The findings were: 1. Review of the 11/4/24 quarterly MDS assessment showed resident #11 (perpetrator) had a BIMS score of 6, indicating severe cognitive impairment. The resident exhibited physical behavioral symptoms 1-3 days during the assessment period. Review of a progress note dated 10/28/24 showed the resident was ambulating to his/her room and encountered another resident. Resident #11 reached over and pinched the other resident in the arm. Review of the care plan showed on 10/28/24 the care plan was updated to reflect the resident to resident altercation. The resident was placed on a 1:1 for supervision following the incident. 2. Review of the 9/6/24 quarterly MDS assessment showed resident #10 (victim) had a BIMS score of 3, indicating severe cognitive impairment. A progress note dated 10/28/24 showed the resident was pinched in the arm by another resident. The resident's arm had bruising and a slight scrape. A 10/28/24 note by the social services director showed the resident had scratch marks with dried blood on his/her arm. Review of an interdisciplinary team (IDT) note dated 10/28/24 showed .Resident has small scrape to right lower extremity as result of altercation, area is being monitored. Social services notes dated 10/28/24, 10/29/24 and 10/30/24 showed the resident was at baseline and no psychological harm was noted. 3. Review of the facility's investigation documentation showed on 10/28/24 resident #11 was witnessed by staff pinching the arm of resident #10. Resident #11 was placed on a 1:1. Resident #10 had a small bruise to the arm. Right after the incident, resident #11 told the CNA that resident #10 was in [his/her] way, but later did not recall the incident. 4. Documentation to show steps taken after the incident was requested, including education to staff, any audits/monitoring, and quality assurance. On 11/14/24 at 1:19 PM the administrator stated the last education on abuse to staff was 8/5/24 (prior to the incident). Review of the provided abuse education confirmed it was 8/5/24. No other documentation was provided.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16146 Based on medical record review and staff and physician interview, the facility failed to ensure monitoring in accordance with physician's orders for 2 of 2 sample residents (#14, #16) with edema. The findings were: 1. Review of the 10/31/24 admission MDS assessment showed resident #16 had diagnoses including heart failure, renal insufficiency, pulmonary hypertension and localized edema. Review of a 10/29/24 progress note by physician #1 showed the resident had 2+ lower extremity edema up to the thighs. Review of physician orders showed on 10/29/24 daily weights were ordered. The following concerns were identified: a. Review of the medical record showed daily weights were not documented on 10/29, 10/30, 11/4, 11/7, 11/8 and 11/10 (the resident was discharged on [DATE]). b. On 11/14/24 at 1:19 PM the administrator stated she was unable to locate any additional weights and confirmed the weights were not done per physician orders. During another interview on 11/14/24 at 3:08 PM the administrator stated the facility did not have a policy, but stated it was standard of practice for nurses to follow physician orders. c. During an interview on 11/14/24 at 4:08 PM physician #1 stated he ordered daily weights to monitor for edema. He stated the daily weights were not done in accordance with orders. 2. Review of the 11/4/24 timed at 11:26 PM progress note revealed resident #14 was crying and stating s/he was worried about his/her swollen legs. Documentation quoted the resident as saying Oh my gosh, I am so worried. My legs are so swollen that I cannot bend them. Documentation by RN #1 indicated trace edema to bilateral lower legs. Review of the 11/4/24 physician progress note revealed documentation of lower leg swelling and weight gain. The note further indicated that the resident gained weight, from his/her admission weight of 254.8 pounds to a weight of 261.8 pounds on 11/4/24. The note further indicated the need to start diuresis and daily weights. Review of the medical record confirmed an order dated 11/4/24 for daily weights for 5 days and to notify the physician if 3 pound gain in 24 hours. The following concerns were identified: a. Review of the treatment administration record for November revealed one weight documented on 11/5/24. b. Review of the vital signs log revealed an admission weight and one weight on 11/5/24. c. Interview with the administrator on 11/14/24 at 1:20 PM confirmed there was an order for daily weights for five days, and stated they were either not done or not documented, I don't know. d. Interview with physician #1 on 11/14/24 at 4 PM confirmed daily weights were not done.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 16146 Based on medical record review, staff and physician interview, and review of policies, the facility failed to provide care in accordance with physician's orders and professional standards of practice for 2 of 2 sample residents (#7, #8) with pressure ulcers. The findings were: 1. Review of the 10/7/24 annual MDS assessment showed resident #8 had one stage 3 and two stage 4 pressure ulcers. The 11/4/24 discharge MDS assessment showed the resident had 3 stage 4 pressure ulcers. Review of the 10/9/24 physician progress note showed the resident was bedbound due to myelopathy of the lower extremities and .recurring sacral pressure sores. despite best efforts to heal [his/her] wounds and work with pressure relief, the pressure sores keep recurring. Review of a progress note by the wound care nurse on 10/29/24 showed .Resident stage 3 on sacrum has developed into stage 4 pressure injury with coccyx palpable and visible. Large amount of drainage observed with slight odor; measuring 12x12x0.8 cm [centimeters] with undermining from 12 to 2 measuring 2.5cm Call made to MD making him aware of current situation. MD also made aware of refusals to be rotated or turned off buttocks; made request for [infectious disease] referral and MD agreed stating that was what family wanted at well. No new dressing order at this time. Staff continue to try to encourage resident to be repositioned throughout day and night. Resident frequently refuses. Review of the 10/29/24 weekly skin assessment for the sacrum wound showed the pressure sore measured 12 x 12 x 0.8 cm with undermining and was a stage 4. Review of the 10/31/24 weekly skin assessment for the right buttock wounds showed two stage 4 wounds, one measured 0.4 x 0.4 x 1.5 cm and the other measured 1.5 x 1.5 x 0.5 cm. Review of a 11/4/24 progress note by the wound care nurse showed [infectious disease] still had not received the referral, and so she encouraged the resident and spouse to allow the resident to go the emergency room to be fully evaluated, including a wound culture swab. The resident was transferred to the ER. During an interview on 11/14/24 at 2:17 PM physician #2 stated the resident has had chronic recurring pressure ulcers and 4 years ago was on comfort care due to wounds. He stated the resident was on an air mattress, had good nutrition and had diabetes control. However, he stated the resident would refuse to allow staff to rotate (reposition) [him/her]. He stated multiple staff told him the resident would refuse repositioning. The following concerns were identified: a. Review of physician orders showed from 10/4/24 to 10/21/24 the sacrum wound dressing was ordered to be changed every shift (twice per day). Review of the October 2024 medication administration record (MAR) showed wound care documentation was lacking on 10/10 day shift, 10/15 day shift, 10/16 day shift, and 10/20 night shift. b. Review of physician orders showed starting 10/22/24 the sacrum wound dressing was ordered to be changed once per day. Review of the October 2024 MAR showed no documentation on 10/25 or 10/30. c. Review of physician orders showed the dressings on the two wounds on the right buttock were ordered to be changed every shift (twice per day) from 10/4 to 10/23. Review of the October 2024 MAR showed no documentation for 10/5 day, 10/10 day, 10/15 day, 10/16 day, 10/20 night, and 10/21 day. d. Review of progress notes for the days of missing documentation showed no evidence the wound care was done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. During an interview on 11/14/24 at 3:08 PM the administrator stated the facility did not have a wound care policy, but stated it was standard of practice that nurses follow physician orders. f. On 11/14/24 at 4:08 PM the administrator stated nursing staff should document when dressings are changed. She further stated they looked at the wound care documentation for resident #8 and found 22 out of 174 times where the documentation was missing. 2. Review of the 10/28/24 admission MDS assessment showed resident #7 with diagnosis of cellulitis of groin, multi-drug resistant organism (MDRO) and encounter for surgical aftercare following surgery on the skin. The following concerns were identified: a. Interview with the wound care nurse on 11/14/24 at 8:50 AM revealed the resident was supposed to have a wound vac placed upon admission to the facility (10/28/24), but the wound vac did not arrive until 10/29/24. The wound care nurse stated she did a dressing change on 10/28/24 with verbal orders from the provider, but did not enter them into the computer. b. Record review revealed only admit orders for the wound vac to be changed Monday, Wednesday and Friday. There lacked orders for wound care until the wound vac was received. c. Review of a progress note dated 10/28/24 at 9:30 AM confirmed the wound was cleansed with wound cleanser, packed with calcium alginate and covered with Optilock and ABD dressing. No other dressing changes were documented in the treatment administration record or progress notes until the wound vac was applied on 10/29/24. d. Review of the facility policy titled, Physician Order Recaps updated April 2024, confirmed that the licensed nursing staff was responsible for inputting admission, telephone and verbal physician's orders into the electronic health record immediately upon receipt from the provider. e. Interview with physician #1 on 11/14/24 at 4 PM revealed he gave the nurse an order for wound care prior to the wound vac arrival and placement as the wound was very wet with a lot of drainage.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16146 Based on medical record review and staff interview, the facility failed to provide medications to meet the needs of the resident for 1 of 11 sample residents (#13). The findings were: 1. Review of the 9/3/24 admission MDS assessment showed resident #13 had diagnoses including abscess liver, CAD [coronary artery disease], hypertension, and diabetes mellitus. Review of a progress note by physician #1 dated 9/26/24 showed the physician documented the following medication changes: a. Start aspirin 81 milligrams (mg) every day for CAD. b. Start Ursodiol 300 mg, three times per day, for pericholecystic abscess. c. For primary hypertension, will stop Furosemide while we monitor volume status. d. For diabetes mellitus, will stop Glipizide and start Empagliflozin 25 mg once per day. The following concerns were identified: a. Review of the medication administration record (MAR) from 9/26/24 until discharge on [DATE] showed the medication changes from the 9/26/24 progress note were never implemented. b. On 11/14/24 at 10:23 AM the DON stated the nurses reviewed physician progress notes, and then she did too. She stated the 9/26/24 progress note was during the transition (she was new to the DON role). c. During an interview on 11/14/24 at 4:10 PM physician #1 confirmed the facility did not implement the medication changes from his 9/26/24 progress note. d. On 11/14/24 at 6 PM the administrator stated the facility received the medications (new medications from the 9/26/24 progress note) from the pharmacy, but they did not get put into the system and the resident did not receive the medications. She stated she spoke to the nurse who signed for the medications and was told the nurse thought they were refills. She did not realize they were new medications.