

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Wind River Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Forest Dr 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility medication error report review, and in-service education review, the facility failed to ensure medications were available for 1 of 4 sample residents reviewed for medication administration. Corrective measures were implemented prior to the survey and compliance was determined to be met on 1/21/26. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a brief interview for mental status score of 13 out 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia, cervicalgia, spina bifida, and morbid obesity. Further review showed the resident received insulin injections on 1 day during the 7-day look-back period. Review of the physician orders showed the resident was ordered alendronate sodium (bisphosphonate) 70 milligrams (MG) per 75 milliliters (ML) by mouth one time per day every seven days for osteoporosis and Zepbound (tirzепtide) 5 MG per 0.5 ML inject 7.5 ML subcutaneously on time per day every Monday related to morbid obesity. The following concerns were identified:a. Review of the resident's medication administration record (MAR) for August 2025 showed the alendronate sodium was not administered on 2 out 3 opportunities for administration and was marked on order from pharmacy on 8/15/25 and 8/22/25.b. Review of the resident's MAR for September 2025 showed the alendronate sodium was not administered on 2 of 4 opportunities for administration and was marked on order from pharmacy on 9/5/25 and 9/26/25. c. Review of the resident's MAR for October 2025 showed the alendronate sodium was not administered on 4 of 5 opportunities for administration and was marked on order from pharmacy on 10/3/25, 10/10/25, 10/17/25, and 10/24/25.d. Review of the resident's MAR for November 2025 showed alendronate sodium was not administered on 4 of 4 opportunities for administration and was marked on order from pharmacy on 11/7/25, 11/14/25, 11/21/25, and 11/28/25. e. Review of the resident's MAR for December 2025 showed alendronate sodium was not administered on 3 of 4 opportunities for administration and was marked on order from pharmacy on 12/5/25, 12/12/25, and 12/19/25. Further review showed the Zepbound was to be administered at a dose of 2.5 mg until 12/1/25, with a start date of 11/9/25. An order for Zepbound 5 mg was ordered from 12/22/25 to the discontinue date of 1/5/26. There was no evidence of an order for Zepbound or administration from 12/1/25 through 12/22/25.f. Review of the resident's MAR for January 2026 showed alendronate sodium was not administered on 4 of 5 opportunities for administration and was marked on order from pharmacy on 1/9/26, 1/16/26, and 1/30/26 and was marked other/see progress notes on 1/23/26. g. Review of a physician's consult dated 12/13/25 showed . Apparently [resident #4] ran out of tirzепtide and one called for a refill, will refill today, reviewed w/ [with] nursing and DON that they need to call our clinics for refills . tolerated the 2.5 mg dose of tirzепtide. SNF [skilled nursing facility] hasn't picked up the alendronate yet, need to do this, reviewed w/ [with] nursing and DON . reviewed with SNF staff need to pick up the alendronate and tirzепtide from [address], do not let [him/her] run out as lapses in tirzепtide can lead to worse side effects .h. Interview with the resident's physician on</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/4/26 at 10:30 AM revealed he had issues with medications not being available and the facility did not notify him, or the facility did not pick up the medications from the pharmacy. The physician revealed he has communicated with the facility and let them know when medications were ordered, they would be available for pick-up between 24 and 48 hours after they were ordered. Further interview revealed if the medications were not available, he was told the facility could get them from a local pharmacy.i. Interview with the administrator on 2/5/26 at 2:01 PM revealed the facility had identified the alendronate and tirzепtide medication errors on 1/20/26 and performed an audit back 30 days. Further interview revealed a performance improvement plan was implemented.j. Review of an Inservice Education Summary dated 1/21/26 showed the training content was If medication is not received from pharmacy, floor nurse is to contact pharmacy and inquire information regarding medication not being delivered and then notify MD regarding missed dosage of medication. Then document notification in PCC [point click care]. 2. Review of the facility's plan of correction dated 1/21/26 showed the following interventions were implemented as a result of the incident:a. A Medication Error/Adverse Drug Reaction Report was completed on 1/21/26 for resident #4's missed Zepbound and Alendronate doses.b. Education was provided to all nurses related to Medication not Received from Pharmacy on 1/21/26.c. Audits were implemented on 1/21/26. 3. The implementation of the plan of correction was verified during the survey.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and policy and procedure review, the facility failed to ensure enhanced barrier precautions were implemented for 1 of 3 sample residents (#4) during wound care. The findings were:1. Review of a telephone order dated 1/11/26 showed resident #4 had an open wound to his/her sacrum. Review of a progress note dated 1/18/26 and timed 11 PM showed the resident had an open wound to his/her right lower extremity. Review of the hospital Discharge summary dated [DATE] showed the resident was discharged from hospital on 1/23/26 where s/he was treated for a right lower extremity wound and cellulitis, had an open sacral wound, and a new foley catheter placement. The following concerns were identified:a. Observation of wound care for the resident on 2/5/26 at 9:22 AM showed the DON and LPN #1 entered the resident's room, performed hand hygiene, and donned gloves. At that time, the DON performed perineal care and foley catheter care due to the resident being incontinent of loose stools. The DON doffed her gloves, performed hand hygiene with soap and water, donned clean gloves, removed a dressing to the resident's sacral wound, and cleaned the wound. The DON doffed her gloves and donned clean gloves, applied a clean dressing, doffed her gloves, performed hand-hygiene, and exited the room. No additional personal protective equipment was used during the wound care.b. Interview with the DON on 2/5/26 at 2:06 PM revealed enhanced barrier precautions should be used for all residents with wounds, catheters, and dialysis or other types of ports. Further interview revealed gloves and gowns should be worn for enhanced barrier precautions during wound care and she confirmed resident #4 should have been on enhanced barrier precautions. 2. Review of the policy titled Transmission-Based Precautions (Isolation) last updated March 2025 showed .Enhanced Barrier Precautions (EBP) are designed to reduce transmission of multidrug-resistant organisms (MDROs). EBP involve the use of gowns and gloves by care providers, during high-contact resident care activities. EBP are used when caring for residents with colonization or infection with a targeted and epidemiologically important MDRO, chronic wounds, or indwelling medical device/s .</p>		