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	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River Snf Operations LLC	1002 Forest Dr Riverton, WY 82501

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff and resident interview, the facility failed to ensure accommodation of resident needs for 1 of 14 sample residents (#1) reviewed. The census was 55. The findings were: 1. Review of the admission MDS dated [DATE] showed resident #1 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia, spina bifida, and morbid obesity. Further review showed the resident was dependent on staff to roll left and right. All other mobility items were coded as not applicable. The following concerns were identified: a. Interview with the resident on 6/24/25 at 2:07 PM revealed the resident was bed ridden and required a wheelchair to get around. The resident revealed s/he was told the facility would get him/her in a wheelchair and assist the resident to bath in the whirlpool; however, s/he had not been out of bed since admitting to the facility. The resident revealed s/he would like to get out of bed and sit in the chair. Observation at that time showed there was no wheelchair in the room or in the hall near the resident's room. b. Interview with the social services director on 6/26/25 at 9:15 AM revealed he had not received any information about the resident's desire to get up or his/her bathing preferences. c. Interview with the facility administrator and DON on 6/26/25 at 9:30 AM revealed the administrator had talked to therapy and thought therapy was trying to get in touch with the resident's family to obtain his/her wheelchair. They confirmed bathing was part of the reason they were attempting to get the wheelchair. They revealed they have a shower chair; however, the resident does not have good trunk control and his/her personal wheelchair was designed for him/her. They confirmed the resident had not been out of bed since admitting to the facility. d. Interview with the regional clinical director on 6/26/25 at 12:10 PM revealed she talked to the therapy department to see if the resident was safe to sit in a wheelchair the facility had available. Further interview revealed therapy spoke with the resident and s/he was going to talk to his/her family about his/her personal chair.

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure a clean environment free of odors in 1 of 4 resident care units. The census was 55. The findings were: 1. Observation on 6/23/25 at 3:06 PM revealed a strong urine odor was present on the hallway near the assisted dining room. 2. Observation on 6/24/25 at 8:37 AM revealed a strong urine odor was present near rooms [ROOM NUMBERS]. 3. Observation on 6/25/25 at 10:26 AM revealed resident #13's room smelled strongly of urine. Staff provided assistance to the resident and the resident left the room; however, the odor remained present in resident's room. 4. Observation on 6/26/25 at 8:10 AM revealed a strong urine odor was present in the assisted dining area. 5. Interview with the facility administrator on 6/26/25 at 9:36 AM revealed the facility was aware of the strong urine odors and revealed the odor had gotten better; however, it still needed improvement. Further interview revealed the facility had been discussing an alternate soiled linen storage on the hall.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure individual activities of preference were provided to 2 of 3 sample residents (#1, #43) reviewed for activities. The findings were: 1. Review of the admission MDS assessment dated [DATE] showed resident #1 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia, spina bifida, and morbid obesity. Further review showed the resident indicated it was very important to have books, newspapers, and magazines to read, music to listen to, and to go outside to get fresh air when the weather was good and s/he was dependent on staff to roll left and right. All other mobility items were coded as not applicable. The following concerns were identified: a. Interview with the resident on 6/24/25 at 2:07 PM revealed the resident was bed ridden and wanted to get up to do things; however, s/he did not have a wheelchair at the facility. S/he revealed s/he was told the facility was going to get him/her a wheelchair; however, they had not gotten one. S/he revealed the facility staff told him/her there was not enough people available to get up. S/he revealed she was unable to go to activities and s/he felt the facility needed more people to go to resident rooms and talk to residents. Observation at that time showed no evidence of a wheelchair in the resident's room or in the hall near the resident's room. b. Review of the resident's activity participation record from 4/12/25 through 6/25/25 showed the resident did not participate in any of the 73 documented group activities and received 1 to 1 activities on 5 days out of 73 days, on 4/16, 4/23, 6/11, 6/18, and 6/20. All other documented activities were indicated as independent. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #43 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder and depression. Review of the admission assessment dated [DATE] showed the resident felt it was very important to listen to music, have books, newspapers, and magazines to read, be around pets, and keep up with the news. The following concerns were identified: a. Interview with the resident on 6/24/25 at 8:41 AM revealed there were no activities at the facility that s/he enjoyed participating in. b. Review of the activity participation record from 3/22/25 through 6/25/25 showed the resident participated in 1 out of 92 documented group activities, on 3/24/25, and received a 1 to 1 activity on 2 days out of 94 days, on 4/1/25 and 5/25/25. All other documented activities were indicated as independent. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Interview with the activities director on 6/26/25 at 8:26 AM confirmed resident #1 was bed bound and revealed she went to see the resident twice per week. She confirmed the documented activity participation for resident #1 and resident #43 did not reflect 1 to 1 activities being performed twice per week. She revealed when resident #1 admitted to the facility, s/he had a lot of family visits and the resident was picked back up for 1 to 1 activities when family stopped coming as frequently. The activity director revealed resident #43 was a night person and she revealed there were no activities for residents at night. She revealed the activities the facility does for younger residents included karaoke, happy hour, and scary movie nights. Further interview revealed resident #43 has participated in scary movie nights; however, neither resident #1 or resident #43 participated in karaoke or happy hour. 4. Review of the facility policy titled Activity Program last revised July 2015 showed .5. Activities include individual, small and large group, one-on-one, and independent activities to meet resident's needs, abilities, and interests. For residents confined to, or who choose to, remain in their room, the Activity Department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, resident interview, representative interview, and policy review the facility failed to ensure residents were safe for 1 of 2 residents (#7) reviewed for elopement. Corrective measures were implemented prior to the survey and compliance was determined to be met on 6/6/25. The findings were: 1. Review of the medical record for resident #7 showed the 4/11/25 admission MDS assessment had a BIMS score of 2 out of 15 which indicated the resident had severe cognitive impairment, as well as verbal behaviors towards others. S/he had a diagnosis of dementia, moderate, with other behavioral disturbance, as well as alcohol abuse, tobacco use, and nicotine dependence, cigarettes. a. The Elopement risk evaluation performed on 4/7/25 showed the resident was not an elopement risk. On 5/22/25 the resident was an elopement risk, and had left the facility without staff knowing. b. The care plan initiated on 4/14/25, showed the resident was an elopement risk/wanderer related to history of attempts to leave the facility unattended, impaired safety awareness, and verbalized wanting to go home. c. Review of a progress notes showed 5/22/25 17:14 [5:14 PM] Resident was noticed missing at 330pm. Resident has been going outside and sitting in the front most of the day because the weather has been pleasant. Resident did not have any voiced wants to leave during that time. Staff noticed that resident was not outside, nor in [his/her] room. Called overhead, but unable to find resident. Staff went out to search for resident in private vehicles, on foot, and searched the building and all rooms. Local law enforcement was called and a report was filed. Approximately 15 minutes later, resident was found walking back towards the facility . When asked the resident where [s/he] went, [s/he] stated [s/he] walked up to the store to pick up some [NAME], which resident did have in [his/her] possession. This writer reminded resident that [s/he] forgot to let us know that [s/he] was leaving and [s/he] replied, oh yeah, I forgot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of a progress note dated 5/30/25 at 11:45 AM showed It was found that [resident name] was not in [his/her] room around 1015AM. An elopement alert was announced, and all staff searched the whole building for [resident name]. Other staff was assigned to start looking outside of the building. While searching [residents name] room, staff found the wanderguard on the floor. [Name of city] Police were notified around 1020am after initial search was completed. Staff found resident walking up the main street around 1035am, unharmed. Staff brought [resident name] back to the facility, but [s/he] refused a full body skin assessment. [Resident's name] was offered a meal and was placed on 1:1 r/t [related to] [him/her] taking [his/her] wanderguard off. Review of a progress note dated 6/11/25 at 1:41 PM showed, This writer spoke with daughter and [ex-spouse] regarding resident's current status. Resident remains on 1 on 1 while awake. Resident is offered to go outside the front and in the courtyard multiple times per day with staff. Resident is offered activities, but usually refuses, except [s/he] likes to watch TV in the TV room. Multiple staff members engage resident in conversations as a distraction when resident talks about going home, which resident does more and more often each day. Resident will become verbally aggressive towards staff when [s/he] feels like [s/he] is being watched, so 1 on 1 will give resident [his/her] space and privacy but knows resident's location at all times. Resident continues to be a high elopement risk, but is not suitable for the secure unit because of the space being small and [s/he] feels enclosed even with the secured courtyard. Will continue to monitor. 2. Observation 6/23/25 at 4:32 PM showed the resident out front of the building, sitting on a bench. S/he was upset that they made him/her come back in. Other observations during the survey showed 1 on 1 staff were within range of the resident during the day. The resident was observed sitting on the bench in front of the building multiple times throughout the survey. Interview with the resident on 6/24/25 at 10:28 AM revealed s/he likes to be outside no matter the weather. S/he used to be a carpenter and likes to be outdoors. 3. Interview with the resident representative on 6/24/25 at 3:06 PM revealed the resident liked to spend time outdoors. She stated the facility was working with her for a more appropriate placement in another facility for the resident. 4. Review of the Performance Improvement Plan (PIP) showed the following: 1. Identified Area for Assessed Improvement: Actual Elopements, High Risk Elopements and Elopement Monitoring. 2. Plan, what is being done: Elopement Risk Audit, Wanderguard System, Unit Placement as needed, and Education. 3. Action Steps to Implement Plan was Audit of High-Risk Elopement, Audit Wanderguards, Update Care Plans, Audit Elopement Evaluations, and Audit/Update Elopement Books. 4. Objective Measures to Evaluate Effectiveness: Initial Risk Assessment upon Admission, Daily Wanderguard Checks for function and placement in TARS, and Weekly Audits of Residents who are High-Risk. The plan was completed on 6/6/25. The staff Inservice Education showed it was completed on 5/27/25 at 2:30 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Interview with the DON on 6/26/25 at 12:04 PM revealed the resident had eloped, and a PIP and staff education had been completed. 6. Review of policy Elopement/Wandering undated February 2025 showed .4. Based on the results of the Elopement/Exit-Seeking Evaluation, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented. The care plan addresses the resident's wandering behavior, potential to exit Center, and/or actual episodes of elopement and the measures taken to manage those behaviors.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, policy and procedure review, and manufacturer recommendation review, the facility failed to ensure medication error rates were not greater than 5% during medication administration for 1 of 4 sample residents (#3) observed during medication administration. The medication error rate was 7.69%, 2 out 26 observations. The findings were: 1. Observation on 6/25/25 at 9:34 AM showed LPN #1 prepared 7 medications for resident #3 which included potassium chloride (mineral supplement) 20 meq (milliequivalents) tablet and duloxetine hydrochloride (antidepressant) 40 mg (milligrams) capsule. Further observation showed the LPN broke open the duloxetine capsule and placed it in a medication cup, then crushed the potassium chloride tablet with other medications before adding it to the medication cup. The LPN added applesauce and administered the medications to resident #3. Review of the physician orders for the resident showed an order May crush meds unless contraindicated dated 11/6/2014, duloxetine hydrochloride delayed release particles 40 mg give 1 capsule by mouth one time a day dated 2/1/25, and potassium chloride extended release 20 meq give 10 meq by mouth one time a day dated 4/2/25. The following concerns were identified: a. Review of the medication label for Cymbalta (duloxetine hydrochloride) delayed release last revised on 10/2010 showed .Cymbalta should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents be sprinkled on food or mixed with liquids . b. Review of the medication label for potassium chloride extended release dated 2013 showed .tablets are to be swallowed whole without crushing, chewing or sucking the tablets . 2. Review of the facility policy provided by the DON and titled Medication Administration General Guidelines dated 01/21 showed .5. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber .b. Long-acting, extended release or enteric coated dosage forms should generally not be crushed; an alternative should be sought .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, policy and procedure review, and the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The census was 55. The findings were: 1. Observation on 6/25/25 beginning at 9:43 AM showed cook #1 prepared a pan of vegetables, doffed her gloves, and placed the pan in the oven. At 9:54 AM she sanitized her hands with Purell gel hand sanitizer, donned gloves and prepared a salad. At 10:09 AM she removed raw meat that was wrapped in plastic from the refrigerator, donned gloves, removed and threw away the meat wrapping, doffed gloves, sanitized hands with gel sanitizer, and seasoned the meat. At 10:19 AM she washed her hands with soap and water. 2. Interview with cook #1 on 6/25/25 at 12:27 PM confirmed she used hand sanitizer if she did not wash her hands in between tasks. 3. Interview with the dietary manager on 6/25/25 at 12:28 PM revealed it was his first time to hear they should not use hand sanitizer in the kitchen. Further interview revealed staff usually used hand sanitizer between gloves after they already washed their hands. 4. Review of the facility policy titled Handwashing and last updated March 2016 showed .Antimicrobial gels cannot be used in place of proper handwashing techniques in a foodservice setting . 5. According to the 2022 FDA Food Code showed 2-301.16 Hand Antiseptics (A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following: (a) Be an APPROVED drug that is listed in the FDA publication Approved Drug Products with Therapeutic Equivalence Evaluations as an APPROVED drug based on safety and effectiveness; or (b) Have active antimicrobial ingredients that are listed in the FDA monograph for OTC Health-Care Antiseptic Drug Products as an antiseptic handwash, and (2) Consist only of components which the intended use of each complies with one of the following: (a) A threshold of regulation exemption under 21 CFR 170.39 -Threshold of regulation for substances used in FOOD-contact articles; Pf or (b) 21 CFR 178 - Indirect FOOD Additives: Adjuvants, Production Aids, and Sanitizers as regulated for use as a FOOD ADDITIVE with conditions of safe use, or, (c) A determination of generally recognized as safe (GRAS). Partial listings of substances with FOOD uses that are GRAS may be found in 21 CFR 182 - Substances Generally Recognized as Safe, 21 CFR 184 - Direct FOOD Substances Affirmed as Generally Recognized as Safe, or 21 CFR 186 - Indirect FOOD Substances Affirmed as Generally Recognized as Safe for use in contact with FOOD, and in FDA's Inventory of GRAS Notices, or(d) A prior sanction listed under 21 CFR 181 - Prior Sanctioned FOOD Ingredients, or (e) a FOOD Contact Notification that is effective, and (3) Be applied only to hands that are cleaned as specified under § 2-301.12. (B) If a hand antiseptic or a hand antiseptic solution used as a hand dip does not meet the criteria specified under Subparagraph (A)(2) of this section, use shall be: (1)Followed by thorough hand rinsing in clean water before hand contact with FOOD or using gloves; or (2) Limited to situations that involve no direct contact with FOOD by the bare hands .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 2 sample residents (#25) reviewed for foley catheters, for 1 of 1 sample resident (#51) with a UTI, for 2 of 2 sample residents (#27, #29) reviewed for respiratory health, for 1 of 4 sample residents (#3) reviewed for medication administration, and during 1 random observation of linen transportation. The findings were: Related to foley catheters: 1. Observation on 6/26/25 at 10:34 AM showed resident #25 was in bed, and his/her catheter bag was on the floor and uncovered. 2. Interview with the DON on 6/26/25 at 12:08 PM confirmed when residents were in bed, the catheter bag should be stored below the residents waist on the bed and with a catheter cover bag. 3. Review of the facility policy titled Catheter and Perineal Care dated 2022 showed .ensure that the catheter bag is secured to a non-movable part of a bed or chair, the tubing is not dragging on the floor, and the bag is below the level of the bladder . Related to UTI: 1. Review of resident #51's medical record showed s/he was diagnosed with pneumonia on 3/21/25 and received Azithromycin 12.5ml (milliliters) by mouth one time a day 3/24/25 through 3/27/25. Further review showed s/he was diagnosed with a UTI on 4/7/25 and received Doxycycline Hyclate 100 mg (milligrams) by mouth 2 times a day for 7 days, 4/7/25 through 4/13/25. 2. Interview on 6/26/25 at 9:08 AM with the resident's representative revealed the resident's tablemate had been ill, and the staff had gone back and forth between the resident and his/her tablemate. Further interview revealed the resident became ill with pneumonia, which caused diarrhea and stomach upset, and then the resident became ill with a UTI. 3. Interview on 6/26/25 at 12:08 PM with the DON revealed there were residents in the facility that had URI or pneumonia in mid March. Related to respiratory health: 1. Observation on 6/23/25 at 3:11 PM showed resident #27's oxygen tubing was balled up on tank, with the nasal cannula resting on the concentrator and the concentrator was on, but not in use. Observation on 6/25/25 at 5:52 PM showed the resident's oxygen tubing was balled up on top of the concentrator. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 6/24/25 at 10:19 AM showed resident #29's oxygen tubing was hanging on his/her concentrator and the nasal cannula was touching the concentrator. Further observation showed the concentrator was against the wall next the resident's bathroom door. Observation on 6/25/25 at 5:50 PM showed resident's oxygen tubing was hanging on his/her concentrator and the nasal cannula was touching the concentrator. Further observation showed the concentrator was against the wall next the resident's bathroom door. 3. Interview with the DON 6/26/25 at 8:19 AM revealed oxygen tubing should be stored in bags when not in use. 4. Review of the facility policy titled Respiratory Care: Equipment Care and Handling last updated November 2018 showed equipment .Storage & waste .Nasal Cannula or Face Mask .Store in mesh bag, paper sack, or in compartment/container between use. Discard in regular waste . Related to medication administration: 1. Observation on 6/25/25 at 9:34 AM showed LPN #1 applied gloves, opened the medication cart, and began removing medications for resident #3. The LPN removed 4 acidophilus capsules, a duloxetine capsule, and 3 phenytoin capsules by placing them on a wash cloth placed on top of the medication cart. Without removing his gloves, the LPN picked up each capsule and broke them open into a medication cup. The LPN then mixed the broken capsules, crushed medications, and applesauce and then administered the medications to the resident. 2. Interview with the DON on 6/26/25 at 11:56 AM revealed nurses should wash their hands when they are going to be handling medications and she would expect gloves to be changed before touching the medications if other items were touched with the gloves. Related to linen transport: 1. Observation on 6/24/25 at 2:44 PM showed an unidentified staff member exited room [ROOM NUMBER] with unbagged soiled linen in her hand. The staff member walked across the hall to the housekeeping closet, was unable to open door, walked toward the end of the hall, and returned to room [ROOM NUMBER]. The linen remained in her ungloved hand during transport. 2. Interview with the DON on 6/26/25 at 11:56 AM revealed soiled linen should be bagged when removed from a resident room. 3. Review of the policy titled Soiled Laundry and Bedding dated May 2015 showed .2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use. 3. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items. 3. Anyone who handles soiled laundry wears protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely) .