STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. Building B. Wing	10/15/2025

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

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 - 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. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility incident review, and policy review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 of 13 sample residents (#2, #3) reviewed for allegations of abuse. This failure resulted in actual physical harm to resident #2 and resident #3. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #2 had a brief interview for mental status score of 14 out 15, which indicated s/he was cognitively intact, and had diagnoses which included schizophrenia and bipolar disorder. Further review showed the resident had physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others on 1 to 3 days during the look-back period. The following concerns were identified: a. Review of a progress note for resident #2 dated 5/14/25 and timed 11:27 PM showed D: Resident to resident aggression. A:Resident [#1] came out of [his/her] room and wanted in the pantry. Resident said everything needed to be locked due to other resident. [Resident #1] then went back to [his/her] room. Staff reported was in the kitchen making popcorn for resident #2]. Resident came out of [his/her] room and asked to call provider [name]. Other resident came toward [#1] with [his/her] laundry basket. [Resident #1] yelled at other resident to stay away and [resident #2] charged at [him/her] and swung at him. [Resident #1] fought back. (The other resident [#2] threw the basket toward [resident #1]). Nurse was called and separated both residents. No injuries noted. [Resident #2] was on floor as other resident was trying to go after [him/her] (pushing toward [him/her] with [his/her] chair) but reports no injury and was not hit by other resident. Guardians, ROC called. Talked to Social Worker [name] about incident. notified providers and DON by email. P: Nursing to follow up as needed. b. Review of a facility incident report dated 5/14/25 showed resident #1 accused resident #2 of stealing his/her food from the pantry. Resident #2 got angry at the accusation and threw a laundry basket at resident #1. Resident #1 attempted to kick resident #2 and then both residents attempted to hit each other. The residents were in a bearhug style and resident #2 attempted to pull resident #1 out of his/her wheelchair. Further review showed no physical injuries were identified.c. Review of a progress note for resident #2 dated 7/14/25 and timed 7:35 AM showed D: Resident to resident incident. A: [NAME] code was called after this resident went after [resident #1] because [s/he] was yelling insults at another resident and was playing [his/her] music way loud and being disruptive. by staff report [resident #2] threw water on [resident #1] through [his/her] doorway and then tried to punch [him/her]. This nurse arrived shortly after green code called. [Resident #2] was actively to hit and kick [resident #1]. [S/He] was redirected by this nurse to create distance and get them calmed down. Another nurse called [name], NP for one time order hydroxyzine 25 mg. there were no injuries noted. P: Nursing to follow up as needed.d. Review of a facility incident report dated 7/14/25 showed at approximately 2 AM, resident # 1 was yelling at resident #2. Resident #1 was calling resident #2 a Fucking Retard and stating resident #2 should die. Resident #1 turned his/her music full blast and started kicking [his/her] door which upset resident #2. Resident #2 stated s/he had enough, obtained a pitcher of water, threw the water on resident #1, and threw punches at resident #1. The residents ended up in the hallway with resident #2 holding onto [resident #1]'s shirt trying to punch and kick [him/her]. After the residents were separated, the RN assessed the residents and identified an abrasion to the leg of resident #1 where resident #2 had kicked him/her. e. Review of a progress note for resident #2 dated 9/17/25 and timed 7:32 PM showed D- Behaviors A- [resident #2] became aggressive towards another resident today. The other resident was calling staff and residents derogatory names and yelling at others. [Resident #2] threw cold water on the other resident then grabbed the other residents glasses off of [his/her] face and threw them onto the floor. A code green was called and Behaviorist [name] took [resident #2] to [his/her] room to help [him/her] calm down, later security also went to [resident #2]'s room and then took [him/her] for a short walk outside. [Resident #2] came back more calm. P- Continue to provide supportive cares. f. Review of a facility incident report dated 9/17/25 showed resident #2 became aggressive towards resident #1 after resident #1 was calling staff and residents derogatory names and yelling at others. Resident #2 threw cold water on resident #1 then grabbed resident #1's glassess off his/her face and threw them on the floor. Resident #1 stated resident #2 broke his/her glasses; however, witnesses stated resident #2 bent the glasses then resident #1 broke them completely.g. Review of a facility incident report dated 9/25/25 showed resident #1 was calling staff and other residents derogatory names. The resident went to his/her room. Resident #2, who was upset by the name calling, went to resident #1's room, threw a beverage on resident #1, jumped on

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility incident report review, state survey agency incident database review, staff interview, and policy and procedure review, the facility failed to ensure timely reporting of allegations of abuse for 2 of 13 sample residents (#1, #2) reviewed for allegations of abuse. The findings were: 1. Review of a facility incident report dated 9/27/25 and timed 4 PM showed resident #1 called resident #2 an asshole and resident #2 threw a cup of juice on resident #1.2. Review of the state survey agency incident database showed the incident was reported on 9/30/25 at 8:12 AM, 3 days after the incident occurred.3. Interview with facility investigator on 10/15/25 at 12:46 PM confirmed the incident was not reported timely. She revealed the incident occurred on a Saturday and at that time, they did not have any staff members who had access to the incident database that worked on the weekends. 4. Review of the facility policy titled Prevention of Resident Abuse, neglect, and Exploitation dated 5/14/25 showed .3. WLRC staff will report the allegation to the Wyoming Healthcare Licensing and Survey (HLS) website immediately, but not later than: Two (2) hours after the allegation is made if the events that cause the allegation involve abuse OR result in serious bodily injury; or Twenty-four (24) hours after the allegation is made, if the events that cause the allegation do not involve abuse AND do not result in serious bodily injury .

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and record review, the facility failed to ensure necessary behavioral health care and services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 13 sample residents (#1) who was reviewed for behavioral health interventions. This failure resulted in actual harm to resident #1. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had a brief interview for mental status score of 15 out 15, which indicated s/he was cognitively intact, and had diagnoses which included cerebral vascular accident, non-Alzheimer's dementia, seizure disorder, traumatic brain injury, anxiety disorder, depression, and psychotic disorder. Further review showed the resident had verbal behavioral symptoms directed toward others 1 to 3 days during the look-back period. Review of the care plan for resident #1 dated 4/3/2024-Present showed Behavioral Symptoms: Baseline Behaviors [resident #1] has exhibited verbal and physical behavioral symptoms directed at self and others. The interventions included When [resident #1] becomes frustrated with other residents, staff will support [resident #1] to plan to ignore and work with them when [s/he] encounters them, rather than calling them names. Staff will offer redirection with preferred activities. Staff will contact nursing if interventions are not effective. Nursing will contact provider if further interventions such as one on one are necessary (which needs to be ordered by the provider). Respond in a calm voice; maintain eye contact. Remove from area if [resident #1] is verbally abusive to others. Escalated behavior management: If [resident #1] is physically or verbally aggressive towards other residents, including threat of harm to other residents, [resident #1] may be assisted from the vicinity of other residents, for other residents' safety. The following concerns were identified:a. Review of a facility incident report dated 5/14/25 showed resident #1 accused resident #2 of stealing his/her food from the pantry. Resident #2 got angry at the accusation and threw a laundry basket at resident #1. Resident #1 attempted to kick resident #2 and then both residents attempted to hit each other. The residents were in a bearhug style and resident #2 attempted to pull resident #1 out of his/her wheelchair. Further review showed no physical injuries were identified.b. Review of a facility incident report dated 6/25/25 showed resident #1 was in an elevated behavior due to outside stimuli and was being aggressive physically and verbally towards other residents in the unit. There were no injuries or outcomes identified.c. Review of a facility incident report dated 7/14/25 showed at approximately 2 AM, resident #1 was yelling at resident #2. Resident #1 was calling resident #2 a Fucking Retard and stating resident #2 should die. Resident #1 turned his/her music full blast and started kicking [his/her] door which upset resident #2. Resident #2 stated s/he had enough, obtained a pitcher of water, threw the water on resident #1, and threw punches at resident #1. The residents ended up in the hallway with resident #2 holding onto [resident #1]'s shirt trying to punch and kick [him/her]. After the residents were separated, the RN assessed the residents and identified an abrasion to the leg of resident #1 where resident #2 had kicked him/her. d. Review of a facility incident report dated 9/17/25 showed resident #2 became aggressive towards resident #1 after resident #1 was calling staff and residents derogatory names and yelling at others. Resident #2 threw cold water on resident #1 then grabbed resident #1's glasses off his/her face and threw them on the floor. Resident #1 stated resident #2 broke his/her glasses; however, witnesses stated resident #2 bent the glasses then resident #1 broke them completely.e. Review of an incident report dated 9/19/25 showed resident #1 had returned from a nature ride and was unloaded on the sidewalk in front of his/her house. Resident #3 was driving his/her wheelchair down the sidewalk towards the Sunflower unit as that was where his friends lived. The incident showed words were exchanged by resident #1 and resident #3 who is non-verbal, and resident #3 hit resident #1 in the head and ran his/her wheelchair into resident #1. Resident #1 hit resident #3 and stated s/he had a right to defend him/herself. The residents were separated and assessed. Further review showed both residents had minor injuries that were treated by the facility.f. Review of a facility incident report dated 9/25/25 showed resident #1 was calling staff and other residents derogatory names. The resident went to his/her room. Resident #2, who was upset by the name calling, went to resident #1's room, threw a beverage on resident #1, jumped on resident #1, and punched resident #1. g. Review of a facility incident report dated 9/27/25 showed resident #1 provoked resident #2 by getting in front of him/her and calling resident #2 an asshole. Resident #2 became escalated and threw juice and the cup at resident #1 and called resident #1 a fucking asshole. 2. Interview with CNA #1 on 10/15/25 at 12:01 PM revealed on 9/19/25 resident #1 and 2 other resident had gone on nature ride. The CNA revealed after