

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Mountain View Skilled Nursing Community at Wlrc		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, facility investigation review, and policy review, the facility failed to protect the residents' right to be free from verbal abuse, physical abuse, and sexual abuse by staff and residents for 3 of 8 sample residents (#4,#12,#16) reviewed for allegations of abuse and neglect. This failure resulted in actual harm to resident #16. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 15 out of 15, which indicated normal cognitive function and diagnoses of non-traumatic brain dysfunction, anxiety and schizophrenia. Review of the quarterly MDS assessment dated [DATE] showed resident #16 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment, and diagnoses which included traumatic brain dysfunction, anxiety and depression. The following concerns were identified: a. Review of the facility incident report dated 3/17/26 showed there had been an incident in the kitchen area between resident #16 and #4 where unknown words were exchanged and resident #4 struck resident #16 in the forehead with a cup. When the staff intervened, resident #4 slipped and fell on the water from the cup. Both residents were separated, removed from the area, and assessed. b. Interview with RN #5 on 4/24/26 at 1:15 PM revealed she left the medication room after she heard a commotion, and saw resident #4 on the ground. She revealed the staff tried to help him/her off the floor and s/he fell again. She revealed when he assessed resident #4 and s/he had a bruise on his/her back and when she assessed resident #16, she found a half circle mark on his/her forehead which looked like the bottom of the cup s/he had been hit with. c. Interview with facility investigator #1 on 4/24/26 at 11:27AM revealed resident #16 had been verbally abusive to staff and continued to mumble negative things when resident #4 retaliated by hitting her/him with the cup. d. Review of a progress noted dated 3/18/26 showed follow up on Head Injury. Assessment first thing this morning. [Resident #16] is awake and alert in [his/her] room. [S/he] reports [s/he] was able to sleep pretty good. Alert to person, place, time and event. Crescent shaped pink area noted to [his/her] left forehead. It does not seem to be tender when I touched the area. 2. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 15 out of 15 which indicated normal cognitive function, and had diagnoses of non-traumatic brain disorder, anxiety and schizophrenia. Further review showed the resident had risk for behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) for 1 to 3 days during the look back period. Review of the care plan dated 1/10/24 indicated that all staff followed the protection from harm policy, protocol, and standard operating procedures. Review of the admission MDS assessment dated [DATE] showed resident #6 had a BIMS score of 4 out of 15 which indicated severe cognitive impairment, and had diagnoses which included traumatic brain injury, Parkinson's disease, psychotic disorder and post-traumatic stress disorder. The following concerns were identified: a. Review of a facility investigation dated 7/10/25 showed resident #6 was in the common area with other residents and staff when s/he stated s/he was going to ejaculate on the nurse's face and then told resident #4 (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	s/he was going to put his/her genitals on the resident's back. Resident #6 then proceeded to expose his/her genitals, make inappropriate sexual gestures, and asked others to touch it. Further review showed the resident urinated on the carpet, a code green was called, and resident #4 was removed from the area.b. Interview with RN #7 on 4/23/26 at 2:10 PM revealed resident #6 demonstrated many threatening behaviors she tried to redirect which worked until the resident exposed themselves, made inappropriate sexual gestures, and urinated on the floor, which triggered her to call the code green. Further interview revealed resident #4 had been upset after the interaction and had to be redirected.3. Review of the quarterly MDS assessment dated [DATE] showed resident #4 had a BIMS score of 15 out of 15, which indicated normal cognitive function, and diagnoses of non-traumatic brain dysfunction, anxiety and schizophrenia. Review of the quarterly MDS assessment dated [DATE] showed resident #12 had a BIMS of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses of intracranial injury, neurogenic bladder, incontinence of bowel and bladder, and hemiplegia. The following concerns were identified:a. Review of the facility investigation dated 3/20/26 showed oncoming staff found resident #12 in his/her clothes from the day before and saturated in urine and feces. The incident review showed feces was also found on the walls, floor, oxygen machine, and on the TV. The incident review showed resident #4 was reported to have been visibly shaking and upset that s/he had to come out of his/her room multiple times during the night to get help and a CNA from another cottage had put resident #12 to bed around 9 PM. Further review showed resident #12's life safety checks were not performed every 30 minutes, CNA #17 and CNA #19 were placed on administrative leave for investigation, and the CNAs were terminated. b. Interview with the facility investigator #1 on 4/24/26 at 11:27AM revealed when she arrived at work on the morning of the incident, she was called to the cottage of the incident where she observed resident #12 was in his/her clothes and shoes from the day before, and there was feces on the resident and all over the room. c. Interview with CNA #21 on 4/24/26 at 12:15 PM revealed he came to work at approximately 6:30 AM the day of the incident and he heard resident #12 yelling for help. When he entered the room, he found the resident had feces all over the room and him/herself, was saturated in urine, and wore clothes and shoes from the previous day. He revealed the resident had a history of digging in his/her brief and spreading his bowel movements when s/he had to sit in them for long periods of time, but he had not seen that behavior from the resident in a year of working there. He revealed he left the room and notified the guide and administrative staff of the situation, cleaned up the resident, and cleaned the room of the mess. He revealed it took him a long time to get the feces off of the resident as it was dried on and difficult to remove. Further interview revealed he was familiar with this resident and the resident did not generally wear his/her shoes and day clothes to bed. d. Interview with social services #1 on 4/24/26 at 4:17 PM revealed when she got to work the day of the incident, the CNAs and guide were frantic about the situation and she instructed them to involve investigations. She observed resident #12's room with feces on walls, bed, floor and TV. She revealed while the staff tended to resident #12, she checked on all the other residents on the unit to make sure harm had not come to anyone else. e. Interview with RN #9 on 4/23/26 at 2 PM revealed she assessed resident #12 after the incident and he did have some redness to the sacral area but no skin break down and it resolved without issue. She revealed resident #4 had been assessed and had calmed down, and had no visible injuries.4. Review of the facility policy titled Prevention of Resident Abuse, Neglect and Exploitation dated 5/14/25 showed . It is the policy and practice of the WLRC that all residents will be protected from abuse and neglect. WLRC will not tolerate any form of resident abuse and will continually monitor facility policies, procedures, training programs, etc., to assist in preventing resident abuse.		

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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** Based on staff interview, medical record review, facility investigation review, professional standard review, and policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 8 sample residents (#10) reviewed for quality of care. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #10 had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment, and had diagnoses which included nontraumatic brain dysfunction, schizoaffective disorder, depression and hypertension. Review of the resident's care plan last revised on 3/19/26 showed a history of delirium, cognitive loss, depression and non-compliance with taking medications. Further review showed the resident did not believe s/he had medical issues and s/he did not need medications. The care plan showed nurses were to approach the resident calmly to inform him/her when it was time for his/her medication and if s/he refused, nursing would politely accept his/her refusal, walk away, and may attempt again later. The following concerns were identified: a. Review of a progress note dated 1/22/26 and timed 3:41 PM showed the resident received his/her monthly Invega medication and it was administered to L [left] flank [the side of the torso between the lower rib cage and the top of the hip bone] area after transfer to w/c [wheelchair] from van. Resident did not flinch or express discomfort or change facial expression during administration. b. Review of a facility investigation dated 11/21/25 showed resident #10 was taken out to eat by the DON and the behavioral analyst. During the outing, the DON administered an Invega injection through the resident's clothing, after the resident refused the medication earlier. The incident review showed the DON stated Sensory modulation techniques were implemented to improve resident tolerance of the injection procedure. Resident provided sensory items, including keys, a beaded lanyard with textured material, and alcohol wipes, were utilized to provide tactile distraction and reduce perceived discomfort during administration. For resident and staff safety, and to reduce risk of physical struggle or injury, the ordered medication was administered via intramuscular injection to the left deltoid through clothing, utilizing nursing clinical judgement based on the resident's history of aggression and inability to safely expose the injection site. Site landmarking was confirmed as accurately as possible under the circumstances. Further review showed the resident wasn't interviewed due to him/her being asleep during the investigation. c. Interview with the DON on 4/23/26 at 3:07 PM revealed resident #10 was given recent Invega injections with the guardian's informed consent. The staff discussed trying new distraction techniques and dining outings, as the resident was food motivated, and the guardian agreed to these trial interventions. Further interview revealed the guardian agreed the resident did need the injection to have an overall improved wellbeing and the resident has a high level of paranoid delusions without medications. d. Interview with social services #1 on 4/24/26 at 4:17 PM revealed she had attempted to contact administration due to resident #10 being taken off campus to sneak a shot on him/her after s/he refused the medication that morning. This made her uncomfortable and she felt the resident should be able to refuse. She went to investigations to get them to check in on the situation since she couldn't get a hold of administration. 2. Review of the manufacturer prescribing information for Invega Sustenna showed .Invega Sustenna is intended for intramuscular use only. Do not administer by any other route. Avoid inadvertent injection into a blood vessel. Administer the dose in a single injection; do not administer the dose in divided injections. Inject slowly, deep into the deltoid or gluteal muscle. 3. Review of Wolter Kluwer's Lippincott Nursing Procedures [Kindle Version], 9th edition, 2023 page 2127 through 2143 showed .IM injection. the site for an IM injection must be chosen carefully, taking into account the patient's general physical status and the purpose of the injection. IM injections shouldn't be administered at inflamed, edematous, or irritated sites or at sites that contain moles, birthmarks, scar tissue or other lesions. IM injections require sterile technique to maintain the integrity of the muscle tissue. avoid distractions and interruptions when preparing and administering (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications to prevent medication errors. to locate deltoid injection site find the lower edge of the acromial process and the point on the lateral arm in line with the axilla. Insert the need 1 to 2 inches below the acromial process, usually 2 or 3 finger breadths, at a 90-degree angle.to locate ventrogluteal Have the patient sit, stand, lie laterally, or lie supine. Locate the greater trochanter of the femur with the heel of your hand. Then spread your index and middle fingers from the anterior superior iliac spine to as far along the iliac crest as you can reach. Insert the needle between the two fingers at a 90-degree angle to the muscle.4. Review of the facility policy titled Administering and Documenting Medications dated 4/1/22 showed .medications shall be administered in a safe and timely manner, and as prescribed.3. Medications must be administered in accordance with the orders, including any required time frame. Staff should consider individual needs and preferences when evaluating medication administration times.20. Staff shall follow established WLRC infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medication, as applicable.		

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F 0689 Level of Harm - 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 staff interview, medical record review, policy review, and facility incident investigation review, the facility failed to ensure adequate supervision was provided for 2 of 8 sample residents (#2, #14) reviewed for accident hazards. The failure resulted in actual harm to resident #2. The findings were: 1. Review of the quarterly MDS dated [DATE] showed resident #2 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment, and had diagnoses of traumatic brain injury, non-Alzheimer's dementia, hemiplegia, and chronic lung disease. Review of the care plan dated 3/7/25 showed the resident had a high to severe risk of choking and aspiration due to the lack of ability to clear his/her throat with textures above puree, and required 1 to 1 supervision and close attention to swallowing during all meals. The care plan showed the resident required a pureed food texture (IDDSI Level: 4) and liquid consistency of moderately thick to extremely thick (IDDSI Level 3-4). Further review showed the resident should not be left around food unsupervised to prevent and reduce risk of choking. The following concerns were identified: a. Review of the facility investigation dated 4/22/25 showed after resident #2 finished her/his meal, which CNA # 3 had been assigned to supervise, the resident had been left at the dining room table while other residents continued to eat. CNA #3 and CNA #7 left the dining area and went to the staff room, and CNA #5 was on a break. When CNA #3 and CNA #7 returned to the dining room they found resident #2 with a slice of pizza. The incident review showed CNA #3 removed the pizza slice from the resident's hands and mouth then left the building for a break. After the pizza was removed from the resident, CNA #5 and CNA #7 observed the resident choking on the remaining pizza and called for help. The incident review showed the nursing staff arrived and provided the resident two to three Heimlich maneuver thrusts and suctioning. Further review showed the incident caused resident #2 to have below normal oxygen levels, required increased supplemental oxygen, and was sent to the ER for evaluation. b. Interview with CNA #3 on 4/24/26 at 1:02 PM confirmed resident #2 was left at the dinner table unsupervised. The CNA revealed she believed the resident was done eating and didn't need further supervision. The CNA confirmed at the time of the incident, there was no staff present in the dining area and the resident obtained pizza from another resident which caused him/her to choke. c. Interview with CNA #7 on 4/24/26 at 2:50 PM confirmed she was with CNA #3 in the staff office after she assisted the resident with the meal, and when she returned to the dining area, resident #2 had pizza in her/his mouth. She confirmed CNA #3 went on break after she removed the pizza from the resident. She confirmed the resident choked on residual pizza after it had been removed, and additional staff responded to clear the resident's airway and send the resident for evaluation. d. Interview with the administrator on 4/24/26 at 4:17 PM revealed the expectation for residents that need supervision varied for each resident, and depended on the areas of supervision that were found in each resident's care plan. 2. Review of the significant change MDS dated [DATE] showed resident #14 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and had diagnoses of moderate non-Alzheimer's dementia, arthritis, osteoporosis and macular degeneration of both eyes. Review of the 11/11/25 and 8/13/25 quarterly MDS assessments indicated the resident had wandering behaviors 1 to 3 days during the look-back period and the impact of wandering had not been assessed. Review of the resident's impaired memory and risk for elopement care plan last revised on 11/18/25 showed interventions which included staff to remain vigilant to the resident's whereabouts and maintain STOP signage on all doors at all times, assure door alarms on outside doors and wander guard are in good working order at all times, and daily reminders for him/her to notify staff when resident is leaving. Further review showed the resident should be assessed for potential physical or emotional reasons for wandering which included depression, need for toileting, water, food or pain relief, restlessness, agitation, symptoms of anxiety, exit watching/seeking, escaping from embarrassment (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and attempts to find someone in charge. The following concerns were identified: a. Review of a progress note dated 12/9/25 and timed 2 AM showed the resident had been up all night, went to speak with the RN in the medication room to report multiple complaints, and then left the room. At approximately 2:15 AM the back door alarm went off and the CNAs and RN found the resident had attempted to get into the door of the adjacent cottage. The resident had his/her walker with food on it and did not wear a coat. Further review showed the resident had been escorted back to his/her residence, had been assessed, and had been found not to have any injuries. b. Review of a progress note dated 4/18/26 and timed 11 PM showed the resident was believed to have left out the front door as the alarm went off. Staff went to assess the alarm to find the front door open and they were not able to see anyone. Room checks were completed and the resident was found missing. Staff then called security to help look for the resident who then found the resident at 11:10 PM in front of the education building. Further review showed the resident was escorted back to his/her residence, was assessed, and was found to have no injuries. The resident stated that s/he was looking for an administrator to talk with about his/her concerns. c. Review of the medical record showed the resident had 15 incidents of elopements between 1/19/25 and 4/18/26 which resulted in the resident being found outside his/her residence without staff knowledge. d. Interview with the facility investigator #1 on 4/24/26 at 11:20 AM revealed on 12/2/25 at 4 PM she was leaving her temporary office in the Sapphire building and found resident #14 outside on the road with a walker. The investigator revealed the resident was upset that no one would engage with him/her inside the residence. The investigator revealed she was able to get the resident into her office, where they spent approximately 20 minutes talking, and then they walked around the campus before they returned to the resident's home. She revealed the resident had been known to wait until everyone was out of the common area before s/he eloped from the residence. Further interview revealed the investigator believed there was an ongoing debate between staff about what was considered elopement. e. Review of an elopement risk assessment dated [DATE] revealed resident #14 attempted elopement weekly with some successful attempts with interventions in place. f. Review of the care conference meetings for the resident on dates 12/3/24, 2/26/25, 5/27/25, 2/4/26 and 3/6/26 showed no evidence that resident elopement had been discussed and no evidence interventions had been evaluated. g. Interview with the administrator on 4/24/26 at 4:17 PM revealed she treated any resident who left a cottage or went to the green lines without staff knowledge as an elopement. She revealed these designations of boundaries depended on resident specific needs and risks, that were found in individual resident care plans. Further she revealed the resident had a wander guard on his/her walker for being high risk for elopement. h. Review of facility policy titled Wandering and Elopement dated 4/2022 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. 6. A care plan identifying wandering and elopement risk will be implemented on admission with quarterly review and as needed.		