

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Wyoming Veterans' Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Veteran's Lane Buffalo, WY 82834	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, incident review, staff interview, and policy and procedure review, the facility failed to protect the residents' right to be free from physical and verbal abuse by a staff member for 1 of 2 sample residents (#3) reviewed for allegations of abuse. This failure resulted in actual harm to resident #3. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #3 had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included hemiplegia or hemiparesis, anxiety disorder, chronic inflammatory skin condition, and restless leg syndrome. Further review showed the resident had upper and lower extremity impairment on one side and required partial/moderate assistance with toilet hygiene and toilet transfer. The following concerns were identified:a. Interview with the resident on 1/21/26 at 10:11 AM revealed CNA #1 hurt him/her and caused pain while providing care. The resident revealed the CNA did not leave any marks and was no longer employed at the facility. b. Review of a facility incident dated 12/26/25 and timed 2:15 PM showed the on-call nurse reported CNA #1 for yelling and cursing at resident #3 during his/her care. The incident report showed the nurse intervened, telling the CNA it was enough, causing her to stop and leave. CNA #1 was immediately sent home, removed from the schedule, and instructed not to return pending investigation. The incident report showed resident #3 requested the CNA to no longer care for him/her, management to be notified, and to file a grievance form. The incident report showed resident #3 reported s/he used his/her call light to request help after an incontinence episode and when CNA #1 entered, she insisted the resident receive a shower, which the resident refused. The resident reported an argument escalated, during which the resident snapped at CNA #2, who originally answered the call light. The incident report showed CNA #1 then yelled at resident #3, began scrubbing [him/her] really hard, and was being intentionally rough. The incident report showed the resident reported asking the CNA #1 to stop and get someone else, which she refused, while continuing to yell. The incident report showed the resident attempted to reach for the call light and the CNA #1 locked the shower chair brakes to prevent him/her from reaching the cord. The incident report showed the nurse entered the room and told the CNA to stop, which ended the interaction. Further review showed the resident reported pain during the incident and soreness following.c. Interview with CNA #2 on 1/23/26 at 8:26 AM revealed on the day of the incident, resident #3 had an issue with loose stools and called for assistance. She revealed she transferred the resident from his/her wheelchair to the shower chair and told the resident they need to transfer in the bathroom. The CNA revealed she found CNA #1 and asked her to help when she was done with what she was doing. At that time, CNA #2 went to get a cleaning cart and when she returned to the resident's room, she heard CNA #1 yelling and arguing with the resident, observed her scrubbing the resident and his/her wound, and heard resident #3 say it hurt and to stop, which CNA #1 refused. CNA #2 revealed she heard CNA #1 say if [the resident] wanted to be</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 535061
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>an asshole, she could be an asshole too. and the CNA told the resident s/he had shit in [his/her] [genitals]. The CNA revealed after she returned to the room, the resident became upset with her and she left the room again. She revealed upon returning to the room again, she heard CNA #1 yell for the resident to stop. CNA #2 revealed she left the room to find the nurse and when the nurse entered the resident's room, the nurse told CNA #1 to stop. CNA #2 revealed following the incident, resident #3 was quiet and mad, and stayed in his/her room. She revealed the resident requested to file a grievance and stated s/he did not want CNA #1 caring for him/her anymore. CNA #2 revealed she felt CNA #1 was being mean and hateful and when they left the room, CNA #2 told CNA #1 she would be mad if they all got in trouble for what CNA #1 had done. Further interview revealed CNA #1 was sent home after the nurse notified the nurse on-call.d. Interview with CNA #1 on 1/23/26 at 8:50 AM revealed on the day of the incident, CNA #2 came and got her to assist with care for resident #3. CNA #1 revealed when she the other CNA had assisted the resident into the bathroom and the CNA did not get his/her pants and brief pulled up all the way, so upon entry to the room, there was feces, urine, and blood all over. CNA #1 revealed she moved the chair to face the wall to attempt to assist the resident with getting his her brief and pants down while CNA #2 went to get cleaning supplies. CNA #1 revealed she attempted to push the shower chair into the shower and resident #3 began to yell. CNA #1 revealed she placed her hand on the resident's shoulder to explain and the resident told her people don't listen to him/her. CNA #1 revealed she assisted the resident to remove his/her shirt and accidentally sprayed cold water on [him/her]. CNA #1 revealed she began to wash the resident and s/he asked her to stop, which the CNA did. CNA #1 revealed the resident asked to see the washcloth and she showed him/her. CNA #1 revealed after she got the resident cleaned up, resident #3 started kicking her. CNA #1 revealed she did tell the resident they needed to get the shit off [him/her]. CNA #1 revealed when she began taking the resident out of the bathroom, the nurse entered and told her to stop talking to the resident, which she did. The CNA revealed she attempted to apologize to the resident and s/he wouldn't listen. After she left the room, CNA #2 would not let her tell the nurse anything and she was told to leave the facility, which she did; however, before she left CNA #2 came out and told her if the CNA or nurse got into trouble over her or her lying, they were going to be upset with her. CNA #1 revealed she was taken off the schedule for weekend and on Sunday, her recruiter called and reported she was not allowed to return to the facility. CNA #1 revealed she did tell the resident #3 if s/he was going to be an ass, the CNA could be an ass and she needed to clean the shit off him/her.e. Attempts to call the RN during the survey were unsuccessful.2. Interview with the DON on 1/23/26 at 9:24 AM revealed she felt the incident was a concern. She revealed she expected staff who witness abuse to ask the perpetrator to leave the room, ensure the resident was safe, and report the incident immediately. Further interview revealed the facility did not implement a formal plan of correction as a result of the incident. 3. Review of the facility policy titled Abuse Policy and Procedure Issued on 12/4/23 showed .It is the policy of (Community) that each veteran will be free from 'Abuse'. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of veteran property and exploitation, corporal punishment or involuntary seclusion . Additionally, veterans will be protected from abuse, neglect, and harm while they are residing at the community. No abuse or harm of any type will be tolerated, and veterans and staff will be monitored for Protection . C. Prevention . Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of veteran property is more likely to occur .</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed psychotropic medications were limited to 14 days for 1 of 6 sample residents (#6) reviewed for unnecessary medications. 1. Review of the quarterly MDS assessment dated [DATE] showed resident #6 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder, insomnia, chronic pain, muscle weakness, and a history of cerebrovascular accident or transient ischemic attack. The following concerns were identified:a. Review of the physician orders dated 12/8/25 showed the resident received Ativan 0.5 milligrams (mg) every six hours as needed for anxiety. There was no evidence a stop date was indicated.b. Review of a monthly medication review dated 12/29/25 showed the pharmacist recommended non-antipsychotic, psychotropic medications be limited to 14 days. Further review showed the physician declined the pharmacist recommendation and deferred to mental health to address. c. Review of the medical record showed no evidence a physician rationale for extended use or a stop date was provided.d. Interview with the DON on 1/23/26 at 8:30 AM revealed that staff were expected to follow up on the monthly medication review orders that were placed in a binder at the nursing station. The DON revealed no additional follow-up for the pharmacist's recommendation was completed or followed up on by mental health services.2. Review of the facility policy titled Medication Regimen Review, last revised 8/17/2023, showed .8. Facility should encourage physician/prescriber or other responsible parties receiving monthly regimen reviews and the director of nursing to act upon the recommendations contained in the monthly regimen reviews .</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure written discharge notice was provided to residents or resident representatives for 1 of 2 sample residents (#24) reviewed for closed records. The findings were: 1. Review of a progress note dated 10/28/25 and 1:05 PM showed resident #24 was involuntarily discharged from the facility. Further review of the progress notes showed no evidence the facility provided a written discharge notice or completed discharge planning prior to the resident's discharge.2. Interview with the DON on 1/22/26 at 4:26 PM confirmed the facility did not issue a written discharge notice or perform discharge planning prior to the resident's discharge.3. Review of the facility policy titled Transfer or discharge date d 12/4/23 showed .The WVSN Social Services Manager (or designee if Social Services Manager is Unavailable) will provide the veteran and family member or legal representative, and the Office of the State Long-Term Care Ombudsman, with a notice of Transfer or Discharge. Notice of Community-initiate transfer or discharge will be provided 30 days before transfer or discharge unless in case of emergency transfer .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level I or PASRR Level II was completed for 3 of 3 sample residents (#4, #12, #23) reviewed for pre-admission screening. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #12 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment, and had diagnoses which included depression and schizophrenia. The following concerns were identified:a. Review of the medical record showed no evidence a PASRR had been completed prior to or following the resident's admission in July 2025. b. Interview with the DON on 1/23/26 at 8:41 AM confirmed that a PASRR was not completed prior to or following the resident's admission.</p> <p>2. Review of a PASRR Level I dated 9/18/25 showed resident #4 had diagnoses which included schizoaffective disorder. Further review showed the resident was marked no for Does this person have a major mental illness according to the three major criteria in 42CFR 483.102(b), Does this person have any history of Mental Illness requiring treatment [NAME] intensive than outpatient services in the past two years, and Is there any presenting evidence of Mental Illness including possible disturbance in orientation, affect or mood that is not attributable to dementia or other medical diagnosis list above. Further review showed the PASRR Level I Screening Summary indicated the decision was no evidence of mental illness or intellectual disability. Review of a PASRR Level II Informed Consent Form dated 10/14/25 showed the resident consented to the completion of a PASRR Level II assessment. Review of the resident's medical record showed no evidence a PASRR Level II was completed.</p> <p>3. Review of a PASRR Level I dated 11/6/25 showed resident #23 had diagnoses which included post-traumatic stress disorder and schizophrenia. Further review showed the PASRR Level I Screening Summary indicated the decision was evidence of mental illness and a PASRR Level II was required. Review of the resident's medical record showed no evidence a PASRR Level II was complete.</p> <p>4. Interview with the DON on 1/22/26 at 2:09 PM confirmed a PASRR Level II should have been completed for resident #4 and resident #23; however, she revealed the staff member responsible for the completion of the assessment was locked out of the PASRR system.</p> <p>5. Review of the policy titled Preadmission Screening and Annual Veteran Review (PASARR) dated 1/1/23 showed .The community will not admit any new Veterans with: Mental Disorder-unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission or Intellectual Disability unless the State intellectual disability or developmental disability authority has determined prior to admission that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing community; and if the individual requires such level of services, whether the individual requires specialized services for intellectual disability .</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to act on pharmacy recommendations for 1 of 6 sample residents (#18) reviewed for unnecessary medications. The findings were: 1. Review of a monthly medication regimen review for December 2025 showed the pharmacy recommended discontinuing hydroxyzine 25 mg, taken as needed for anxiety. Further review showed the physician accepted the pharmacy recommendation and ordered hydroxyzine to be discontinued. Review of the physician orders showed the hydroxyzine had not been discontinued. 2. Interview with the DON on 1/23/26 at 8:30 AM confirmed the medication had not been discontinued. 3. Review of the facility policy titled, Interim Medication Regimen Review, last updated 2018, showed the physician/prescriber should .6.1. Accept and act upon the recommendations contained within the monthly medication review .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label and provide the date medications were opened in 1 of 2 two cottages (Cottonwood). The findings were: 1. Observation on 1/22/26 at 8:24 AM showed an Insulin Glargine 100 unit/1 milliliter (ML) pen which was opened, partially used, and not dated. 2. Interview with RN #1 on 1/22/26 at 8:24 AM revealed the insulin pen had been used and confirmed insulin pens should have been labeled with the opened date. 3. Interview with the DON on 1/23/26 at 10:12 AM confirmed staff were expected to label multi-dose insulin with the date it was opened.4. Review of the facility policy titled Multidose Vial Use dated August 2024 showed, .A.1. All multi-dose vials are dated with a 28-day expiration date, as the last date that a product is to be used.A.2. All multi dose vials are labeled with the expiration date at the time of original opening by the person initially accessing the multi-dose vial .5. Review of the insulin manufacturer recommendations titled Highlights of Prescribing Information last revised 2025 showed .Only use your pen for up to 28 days after it's first use .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interview, policy and procedure review, and food code review, the facility failed to ensure food was stored in accordance with professional standards for food service safety. The census was 24. The findings were: 1. Observation of the warehouse walk-in freezer on 1/22/26 at 10:12 AM showed a black plastic bag was positioned near the entry door, on the floor. Interview with the dietary manager at that time, revealed the bag contained a cow hide, which was his personal item, and he was planning to remove it that day. The manager stated the hide had not been in the freezer long and he confirmed the other items in the freezer were for resident consumption. Observation on 1/22/26 at 11:14 AM showed the dietary manager tore open the black plastic bag which revealed what appeared to be a cow hide, with black hair, folded onto itself in a square. The hide was visibly frozen with ice accumulation on the flesh and hair.</p> <p>2. Interview with the facility administrator on 1/22/26 at 11:21 AM revealed he was aware the hide had previously been in the freezer and he thought it had been removed. The administrator revealed he heard about the hide over the summer and had asked the dietary manager to take it out, which he thought had occurred. He revealed it was unsure if the hide had been removed and returned to the walk-in freezer. Further interview confirmed the hide should not have been stored in the walk-in freezer.</p> <p>3. Review of the policy titled Food Prep and Storage dated 12/4/23 showed .9.Protect food from contamination or cross-contamination during preparation, services and storage through precautionary measures in accordance with current food code guide, including use of clean, properly sanitized equipment; optimum refrigerator temperatures; proper handling of food by healthy personnel who wash hands thoroughly after touching any food or objects that may be contaminated; and storage and use of poisonous or toxic materials away from the food .</p> <p>4. Review of the 2022 Food Code, US Food and Drug Administration, showed .3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) Except as specified in &para;&para; (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor .</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on payroll based journal staffing report review, and staff interview, the facility failed to ensure mandatory submission of staffing data. The census was 24. The findings were:1. Review of the fiscal year 2025 quarter 2 (January 1-March 31) payroll based journal staffing report showed the facility triggered for the metric Failed to Submit Data for the Quarter.2. Review of the fiscal year 2025 quarter 3 (April 1-June 30) payroll based journal staffing report showed the facility triggered for the metric Failed to Submit Data for the Quarter.3. Review of the fiscal year 2025 quarter 4 (July 1-September 30) payroll based journal staffing report showed the facility triggered for the metric Failed to Submit Data for the Quarter.4. Interview with the DON on 1/23/26 at 8:30 AM revealed the facility was aware the payroll based journal reporting was not consistent. Further interview revealed the previous HR director had inconsistent access to the payroll based journal reporting system.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy and procedure review the facility failed to ensure the residents were immunized for pneumococcal disease in 1 of 5 sample residents (#12) reviewed for current vaccination status. The findings were:1. Review of medical record for resident #12 showed his/her most recent Pneumococcal Conjugate Vaccine (PCV13) was administered on 10/18/19, and the facility planned to administer Prevnar 20 at the time of admission in July 2025; however, there was no record the resident received the vaccine. Review of the resident vaccine consent form dated 7/9/25 showed the resident had consented to receive the pneumonia vaccine. 2. Interview with the Infection Preventionist on 1/23/26 at 10 AM confirmed the resident did not receive the vaccine. 3. Review of the facility document titled Wyoming Veterans' Skilled Nursing Policies and Procedures. dated 12/2023 showed .1. Prior to or upon admission, Veterans will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the community unless contraindicated .7. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with the current Centers for Disease Control and Prevention recommendations at the time of the vaccination .4. Review of the Centers for Disease Control Vaccines and Administration Schedule, last revised 2025 showed .Adults over [AGE] years of age who previously received one dose of PCV13 should receive one dose of PCV20 or one dose of PCV21 at least 1 year after the last PCV13 dose .</p>		