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 _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/30/17 to 11/2/17. Also reviewed in the course of the survey were complaint intakes WY000002349, WY000002483, WY000002487, WY000002497, WY000002507, WY000002510, and WY000002511. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CAA: Care Area Assessment CNA: Certified Nurse Aide DNS: Director of Nursing Services LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 172 SS=D	RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS CFR(s): 483.10(f)(4)(i)-(vi) (f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State,	F 172		12/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/27/2017

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.

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F 172	Continued From page 1 (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq), (F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and (G) The resident representative. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	F 172		

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F 172	Continued From page 2 (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. (vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.	F 172		

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F 172	Continued From page 3 (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 1 residents (#56) with visitation restrictions was made aware of the visitation restriction. The findings were: Review of the 8/12/17 quarterly MDS assessment showed resident #56 was able to understand, and usually understood others. The resident had moderate cognitive impairment with a BIMS score of 10/15. Review of a health care power of attorney (POA) document signed and dated January 1, 2013 showed "If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she has made if I am able to understand." The following concerns were identified: a. Review of the 10/24/17 timed at 1 PM nurse's note showed when one of the resident's local family members (who was not the resident's POA) visited, the resident became interested in moving to another facility. The resident was noted to get "agitated." The staff attempted to calm the resident, and explained the POA would have to make any arrangements to move. The note then showed the POA was contacted and "POA explained there was to be no further contact [with] resident and [family member]." b. Review of the social service note dated 10/24/17 showed the POA wanted to "stop visitation for a while" between the resident and the other family member. The note showed the	F 172	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Corrective Actions Resident #56 was made aware of visitation rights limitations ordered by POA on 11/21/2017. SSD, family member, ombudsman, and ED met to discuss visitation rights for resident #56. Identification of Others ED/designee identified all residents with limited visitation rights and review POA documents to ensure they are in force and POA visitation rights limitations are being respected with corresponding care plan in place. No other residents with limited visitation rights identified. ED/designee re-notified all responsible parties are of visitation rights on 11/22/2017.	

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F 172	Continued From page 4 family member was notified by the POA regarding the decision. However, the notes failed to show the decision to limit visitation was discussed with the resident. c. Review of a note taped to the inside cover of the medical record showed the resident was "not allowed to call [family member] per: nurse." d. Review of the medical record failed to show any plan related to the details of the limited visitation. e. Interview with the DNS on 11/2/17 at 11:04 AM verified the resident's family member was known to visit, but the frequency was uncertain. The DNS stated there was not a visitation plan she was aware of. She further verified the resident was able to understand, and any limitations on the visits needed to be communicated to the resident.	F 172	Systemic Changes ED and DNS educated SSD, charge nurses, and admissions coordinator on F172 requirements and necessity to check with Power of Attorney documentation in place and active before limit rights on 11/22/2017. DNS/designee re-educated all staff on visitation rights on 11/20/2017. SSD will review resident rights and visitation rights during care conferences. Monitoring for Compliance All visitations rights limitations to be monitored for compliance on a weekly basis for the next three months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days. DNS/designee will audit random families of new residents for understanding of visiting hours.	
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure safe self-administration medication practices	F 176	Corrective Actions DNS assessed Resident #15, #16, and #27 on 11/21/2017 and found them not	12/1/17

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F 176	Continued From page 5 were implemented during random observations of 3 residents (#15, #16, #27). The findings were: 1. Observation on 10/30/17 at 5:23 PM showed LPN #1 delivered medications in a medication cup to resident #16. The nurse placed the cup containing medications on the table in front of the resident, then walked away without observing the resident take the medications. Review of the medical record showed the resident had diagnoses that included vascular dementia. The record showed safe swallowing strategies were recommended, including a double swallow and effortful swallow. Review of the nursing admission evaluation dated 6/30/17 showed no evidence the resident had the desire to self-administer medications. Further review of the medical record showed no evidence the resident had been assessed and deemed appropriate for self-administration of medications. 2. Observation on 10/30/17 at 5:29 PM, showed LPN #1 set a medication cup with medications in it in front of resident #27 and left him/her to take the medication without observation. Review of the medical record showed the resident had a diagnosis of dementia and was incapable of making his/her own decisions. Review of the quarterly nursing evaluation dated 7/15/17 showed no evidence the resident had the desire to self-administer medications. Further review of the medical record showed no evidence the resident had been assessed and deemed appropriate for self-administration of medications. 3. Observation on 10/30/17 at 5:55 PM showed LPN #2 delivered medications in a medication cup to resident #15. The nurse placed the cup containing medications on the table in front of the	F 176	able to demonstrate the ability to self-administer medications on 11/20/2017. LPN 1& 2 both received re-education on medication administration on 11/2/2017. Identification of Others DNS/designee conducted random audits for compliance to medication administration for all residents. Random medication pass audit was conducted on 11/2/17 by DNS/designee. No other deficiencies identified. Systemic Changes On 11/3/17 DNS re-educated all nurses on medication administration. DNS re-educated all nurses on medication administration policy and procedure and requirements for resident medication self-administration on 11/20/2017. Monitoring for Compliance DNS or representative will conduct random weekly audits of medication administration for four weeks and then monthly for two months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	

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F 176	Continued From page 6 resident, then walked away without observing the resident take the medications. Review of the medical record showed the resident had diagnoses of cerebral vascular accident, osteoarthritis, and hemiplegia. Review of the quarterly nursing evaluation dated 10/1/17 showed no evidence the resident had the desire to self-administer medications. Further review of the medical record showed no evidence the resident had been assessed and deemed appropriate for self-administration of medications. 4. Interview with the DNS on 11/2/17 at 8:53 AM revealed it was her expectation medication would not be left with the residents. Further, she stated the facility had only one resident that self-administered medications.	F 176		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect,	F 225		12/1/17

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F 225	Continued From page 7 exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated	F 225		

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F 225	Continued From page 8 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of employee records, staff interview, and review of policies and procedures, the facility failed to ensure pre-employment screening of the nurse aide abuse registry was completed for 2 of 3 CNAs reviewed (CNA #1, CNA #2). The findings were: 1. Review of the employee file for CNA #1 showed a date of hire of 9/22/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to the hire date. 2. Review of the employee file for CNA #2 showed a date of hire of 10/18/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to the hire date. 3. Interview with the staff development coordinator on 11/1/17 at 9:20 AM verified the nurse aide abuse registry had not been checked prior to the date of hire for the identified employees. 4. Review of the policy and procedure titled, "Screening" revised September 2017, showed "...5. The Center does not hire or engage an individual who:...b. Has had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents;..."	F 225	Corrective Actions Nurse aide abuse registry has been run for CNA #1 and CNA #2 on 11/22/2017. Identification of Others Audit of all aides for documentation of State nurse aide abuse registry was conducted on 11/22/2017 by ED/designee. Systemic Changes SDC/designee will be conducting nurse aide abuse registry check. ED/designee in-serviced SDC to not assign new hires any duties that include contact with residents, until all background checks, including State aide abuse registry, is complete and passed on 11/22/2017. Monitoring for Compliance All aides hired in the next three months will be audited for state aide abuse registry check documentation occurring before hire date by ED or DNS. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	

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F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an environment free from maintenance concerns in 2 of 3 units (Red Canyon, Owl Creek). The findings were: 1. Observation on 11/1/17 at 3:47 PM identified the following maintenance concerns: a. In Owl Creek's television area, the vinyl chair had a rip in the cushion that measured 2 inches by 3/4 inch, and exposed the foam cushioning which could not effectively be cleaned. b. The bathroom door in resident room 32 had a rip in the kick plate, which was peeling up from the surface of the door. The rip measured 5 inches long and was 4 inches from the bottom of the door. c. The bathroom door in resident room 31 had a hole that measured 1 inch by 2 inches, and exposed rough splintered wood. d. The countertop in resident room 31 had peeling laminate along the back border that measured 23 inches long. e. The wall along the countertop in resident room 8 had chipped and missing paint that measured 6 inches by 3/4 inch, and created a surface that could not effectively be cleaned. 2. Interview with the maintenance supervisor on 11/2/17 at 9:20 AM verified the identified areas needed to be addressed.	F 253	Corrective Actions Chair in Owl Creek TV area is no longer in the facility as of 11/20/2017. Kick plate was repaired 11/22/2017. Door in resident room repaired 11/22/2017. Laminate on countertop in resident room 31 repaired 11/24/2017. Wall along countertop in room 8 will be mudded and painted to create cleanable surface on mudded on 11/22/2017 and painted on 11/25/2017. Identification of Others ED/ designee conducted audit of all chairs in resident areas to be free from tears, rips, or other exposed foam cushioning on 11/22/2017. One chair disposed of 11/22/2017. ED/designee conducted audit of all kick plates for being without rips on 11/22/2017. All deficient kick plates were repaired by 11/25/2017. ED/designee audited all doors in the facility for holes on 11/23/2017. No deficiencies found. ED/designee audited all laminate surfaces in resident areas for peeling on	12/1/17

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F 253	Continued From page 10	F 253	11/22/2017. All deficient laminate surfaces were repaired by 11/25/2017. ED/designee conducted audit of all countertop walls in patient areas for paint chips. No other deficiencies found. Systemic Changes ED/designee re-educated all staff on reporting to maintenance director on 11/23/2017. ED/designee re-educated Maintenance director on timely response to maintenance requests and infection control standards for furniture, kick plates, doors, laminate surfaces, and painted surfaces on 11/23/2017. Inspections of chairs, kick plates, doors, laminate surfaces, and painted surfaces to be placed in implemented in preventative maintenance program. Monitoring for Compliance ED and maintenance director will repeat all audits weekly for four weeks and then monthly for 2 months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	
F 272 SS=E	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a	F 272		12/1/17

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F 272	Continued From page 11 resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident,	F 272		

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F 272	Continued From page 12 as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and Resident Assessment Instrument (RAI) manual review, the facility failed to ensure comprehensive analysis of resident needs in a variety of areas for 7 of 11 sample residents (#4, #22, #31, #38, #39, #63, #64). The findings were: 1. Review of the 9/4/17 significant change MDS assessment for resident #4 showed the areas triggered for comprehensive assessment included: ADL Functional/ Rehabilitation Potential, Urinary Incontinence, and Communication. Review of the CAAs for these areas showed they were incomplete without detailed analysis to support development of the care plan. 2. Review of the 10/23/17 significant change MDS assessment for resident #22 showed triggered areas that required additional assessment included: Cognitive Loss/ Dementia, ADL Functional/ Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the CAAs for these areas showed a lack of analysis related to the care area to support the care plan decision. 3. Review of the 8/4/17 annual MDS assessment showed resident #31 required comprehensive assessment for triggered areas including: Cognitive Loss, Behavioral Symptoms, Psychosocial Well-being, Urinary Incontinence, Visual Function, and Communication. Review of the CAAs for these areas showed the analysis of	F 272	Corrective Actions Divisional MDS Utilization Review Nurse re-educated MDS nurse on detailed analysis in Care Area Assessment to support creation on 11/02/2017. Identification of Others MDS will conduct identification of other currently open CAAs for detailed analysis to support care plan. Systemic Changes Divisional MDS Utilization Review Nurse educated MDS coordinator and DNS on detailed analysis requirements and language to support care plan on 11/2/2017. DNS/designee educated SSD, Activities manager, and MDS backup on CAA analysis on 11/2/2017. SSD educated by ED/designee to complete CAAs triggered by MDS sections that SSD completes on 11/15/2017 Monitoring for Compliance Based on the MDS schedule, CAA will be audited by MDS and DNS weekly for 3 four weeks and then monthly for two months for detailed analysis to support care plan by MDS nurse. Deficiencies will be corrected before submission. Results of the audits will be brought to	

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F 272	Continued From page 13 the data was lacking or incomplete. 4. Review of the 10/17/17 significant change MDS assessment for resident #38 showed triggered areas that required a comprehensive assessment included: Communication, Behavioral Symptoms, Activities, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the CAAs for these areas showed a lack of analysis related to the care area to support the care plan decision. 5. Review of the 11/30/16 annual MDS assessment for resident #39 showed the following areas triggered and required a comprehensive assessment: Delirium, Cognitive Loss/Dementia, Communication, Urinary Incontinence, Behavioral Symptoms, Falls, Dental Care, and Pressure Ulcer. Review of the CAAs for these triggered areas showed they were incomplete, were not individualized to the care area, and lacked an analysis of the data to support the care plan. 6. Review of the 10/17/17 significant change MDS assessment showed resident #63 required comprehensive assessment for triggered areas including: Cognitive Loss, Nutritional Status, Falls, and Pressure Ulcer. Review of the CAAs for these areas showed the analysis of the data was lacking or incomplete. 7. Review of the 8/29/17 admission MDS assessment for resident #64 showed the following areas triggered and required a comprehensive assessment: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure	F 272	monthly QAPI meeting for review and recommendation for 90 days.	

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F 272	Continued From page 14 Ulcer, and Psychotropic Drug Use. Review of the CAAs for these triggered areas showed they were incomplete, were not individualized to the care area, and lacked an analysis of the data to support the care plan. 8. Interview with the MDS coordinator on 11/2/17 at 8:50 AM revealed she had been in the position approximately 5 months and she and the social service designee were responsible for completing the CAAs. She verified the analysis was lacking in some cases and could be more comprehensive. 9. According to the CMS RAI version 3.0 manual: "...The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to the resident's possible problems, needs, or strengths. The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs [Care Area Triggers] is the basis of the Care Area Assessment process and can help provide additional information for the development of an individualized care plan."	F 272		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		12/1/17

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F 280	Continued From page 15 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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F 280	Continued From page 16 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan was updated and accurate for 1 of 13 sample residents (#4). The findings were:	F 280	Corrective Actions Resident #4 care plan updated to include increased supervision on 10/30/2017 and staff not leaving resident room while	

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F 280	Continued From page 17 1. Review of the 9/4/17 significant change MDS assessment showed resident #4 was moderately impaired for daily decision making, and required limited assistance with the physical assist of 1 staff member for toileting. Review of the interdisciplinary team fall reviews showed the resident fell without injury while in the bathroom on 9/8/17, 10/16/17, and 10/30/17. These falls were reviewed and the recommendation after the falls included increasing the level of assistance and to not leave the area while the resident was in the bathroom. The following concerns were identified: a. Review of the fall risk care plan showed it was last updated on 10/27/17 and the intervention to not leave the area while the resident was in the bathroom was not included. b. Review of the "Care Directive Form" used by the CNAs showed it was dated 10/24/17 and the intervention of not leaving the area during toileting related to falls/safety was not included. c. Interview with the DNS on 11/2/17 at 9 AM revealed staff education was done related to the fall recommendations on 10/30/17. However, she verified the information was not reflected on the resident's care plan or care directive form.	F 280	resident is in bathroom. Resident #4 care directive was updated 10/30/2017. Identification of Others Audit of all current care plans being resident-centered and up-to-date completed on 11/22/2017. Systemic Changes DNS/designee provided education to staff to follow care plan directives on and follow instructions in alterations of safety 10/30/2017. DNS/designee finished re-educating nurses on keeping care plans up-to-date on 11/3/2017. DNS/designee re-educated all nursing staff on following care plans on 11/3/2017. Monitoring for Compliance DNS/designee will conduct random audits of ensuring care plans are updated weekly for four weeks and monthly for 2 months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329		12/1/17

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F 329	Continued From page 18 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure residents' medication regimens were free from unnecessary medications for 1 of 13 sample residents (#31). The findings were: Review of the 8/23/17 Behavior Medication	F 329	Corrective Actions Resident 31 has completed GDR response from the physician on 11/21/2017. Identification of Others SSD/designee conducted facility-wide	

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F 329	Continued From page 19 Review Form showed resident #31 had a 1/6/16 order for Trazodone (anti-depressant medication) 50 milligrams (mg) to be given at bedtime. The form also showed an additional order was started 6/3/16 for Trazodone 25 mg three times per day. The column to show the "last change" in the medication was blank. The interdisciplinary team recommendations on this form were to change the diagnosis for the Trazodone to "Dementia [with] behaviors." Review of the 8/23/17 medication regimen review showed the pharmacist identified the resident was receiving both doses of Trazodone "without clear diagnosis." The following concerns were identified: a. Review of the October 2017 medication administration record (MAR) showed the resident continued to receive the two ordered doses of the Trazodone for "Restlessness and Agitation." In addition, the MAR notes showed on 10/19/17 two doses of the 25 mg Trazodone were held due to "sleepiness." On 10/26/17 two doses of the 25 mg and the 50 mg bedtime dose were held due to "sleepiness." On 10/28/17 the note showed the 12 PM dose of Trazodone was held due to "lethargy and [increased] sleep- unable to rouse [resident] to take meds." b. Interview with the DNS on 11/2/17 at 8:10 AM verified a gradual dose reduction (GDR) of the Trazodone had not been attempted. Further, there was no documented contraindication to a GDR. c. Review of the "Psychotropic Drugs" policy, updated September 2017, showed "Gradual dose reductions consist of tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether...Residents taking a psychoactive medication unless clinically	F 329	audit on 11/15/2017 to confirm residents with prescribed psychoactive drugs received GDR and behavior intervention timely. No residents found to need GDR. Systemic Changes DNS/designee provided re-education to SSD relating to requirements of physician review of GDRs on 11/20/2017. Members of psychoactive medication review team in-serviced on GDR requirements on 11/20/2017 and to follow up GDR requests. Monitoring for Compliance Audits shall be conducted by DNS or designee relating to physician review of GDRs weekly for four weeks then monthly for two months. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	

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F 329	Continued From page 20 contraindicated, undergo a gradual dose reduction."	F 329		
F 363 SS=D	MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)-(7) (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the planned menu, review of diet orders, and staff interview, the facility failed to ensure portion sizes were followed for 1 of 1 residents (#38) observed with a pureed diet. The findings were:	F 363	Corrective Actions Replaced #12 scoop for all servings with a #8 for pureed pot roast, #8 for pureed boiled potatoes, and #16 scoop for pureed baby carrots, as set forth in menu, on	12/1/17

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F 363	Continued From page 21 Review of the planned menu on 11/1/17 showed the following serving sizes for the noon meal: 4 ounce (oz) (#8 scoop) of pureed pot roast, 4 oz (#8 scoop) of pureed boiled potatoes, and 2 oz (#16 scoop) of pureed baby carrots. Observation on 11/1/17 at 12 PM showed resident #38 had a diet order for a pureed meal. Cook #1 used a #12 scoop, equivalent to a 2.5 to 3 ounce portion, to serve each of these items. Based on the portion served, the resident received less than the planned portion for the pot roast and the potatoes. Interview with cook #1 on 11/1/17 at 12 PM verified she was uncertain of the portion size for the scoop being used. Interview with the dietary manager on 11/1/17 at 12:15 PM verified the scoop the cook used was a #12 size. The manager made the needed correction so the remainder of the service was accurate. The manager confirmed the menu was not followed and more education was needed related to portion sizes.	F 363	11/1/2017. Serving tool relating to portion size was corrected immediately, per surveyor documentation. Identification of Others FANS manager corrected behavior immediately, per surveyor documentation. FANS manager will audit through observations correct portion sizes being used, per menu. Systemic Changes Dietary Consultant re-educated cooks on 11/1/2017 on using correct scoop size and preparing correct portion sizes as outlined in menus. FANS manager/designee will audit entire meal services to verify that the scoop size used is compliant with menu. Monitoring for Compliance FANS manager to conduct random audits of more than 50 percent of meals per week for four weeks and then weekly for eight weeks. Deficiencies to be corrected immediately. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		12/16/17

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F 371	Continued From page 22 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure proper hand hygiene and cleanliness of equipment and surfaces in 1 of 1 kitchens. The findings were: 1. Observation on 10/30/17 at 3:02 PM and 11/1/17 at 11:03 AM showed the hood vents above the range and griddle were soiled with thick accumulated dust and grease. The cutting surface of the steam table was noted to be constructed of wood and was scored with discoloration and grooves. The surface was no longer cleanable due to the wear. 2. Observation on 11/1/17 from 11:03 AM to 12:15 PM showed the following: a. The fans and area around the fans located	F 371	Corrective Actions Refrigerator fans and area around fans have been cleaned on 11/22/17. Sink cleaned 11/1/2017. Back wall, back of cooking equipment, and floor behind cooking equipment are clean and free from dust and food particles. Hood cleaned 11/21/2017. New cutting surface has been ordered and will be installed upon delivery. Cook #1 in-serviced on hand hygiene on 12/14/2017. Identification of Others ED and FANS manager inspected entire kitchen focusing on areas behind large	

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F 371	Continued From page 23 in the walk-in refrigerator were soiled with dust. b. The wall located by the 3-compartment sink was in need of cleaning, it was soiled with food and splattered debris. c. The area behind the cooking equipment was in need of cleaning. There was grease and food build-up on the wall, sides of the equipment, and the floor. 3. Observation of food preparation on 11/1/17 at 11:35 AM, and 12:10 PM showed cook #1 contaminated her gloves by handling the refrigerator doors. After the contamination the cook failed to perform hand hygiene and continued to handle food and clean items with the gloves. 4. Interview with the dietary manager on 11/1/17 at 3:37 PM revealed additional training was required for hand hygiene. The manager also verified the areas identified were in need of cleaning, and the cutting surface of the steam table needed to be replaced. 5. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands." 6. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other	F 371	equipment. Deficiencies were corrected immediately. All residents at risk. Systemic Changes FANS manager/designee re-educated FANS personnel on cleanliness standards on 11/24/2017, reporting deficient areas, and cleaning practices. FANS manager to conduct weekly audits, fixing deficiencies at point of inspection. Apparent deficiencies to be fixed regardless of cleaning schedule. Cleaning schedule to be followed. ED/designee re-educated FANs personnel on hand hygiene on 12/15/2017. Monitoring for Compliance FANS manager and ED will audit weekly for cleanliness for next 3 months. ED/designee will conduct random weekly visual audits on appropriate hand hygiene practices weekly for 90 days. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	

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F 371	Continued From page 24 debris."	F 371		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441		12/1/17

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 _____	C 11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure infection prevention practices were implemented during 1 random observation. The findings were: Observation on 10/31/17 at 11:57 AM showed CNA #3 rolled up soiled linens from a resident's	F 441	Corrective Actions Staff re-educated on dirty linen transport policy and procedure by DNS/designee on 11/3/2017. Identification of Others All residents at risk from deficient practice.	

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F 441	Continued From page 26 bed and carried the linens out into the hall to the soiled linen room. The linens were un-bagged and the CNA was not wearing gloves during transport. Interview on 11/2/17 at 9:54 AM with the infection control officer confirmed linen was to be bagged or put in a container prior to entering the hallway. Further, she stated that gloves were to be worn by staff when handling soiled linen. Review of the policy on soiled laundry and bedding, published May 2015, showed "...3. Place and transport contaminate laundry in bags or containers ... 4. Anyone who handles soiled laundry wears protective gloves ..."	F 441	Systemic Changes DNS/designee provided re-education to all nursing staff (LNs, CNAs, and HAs) related to the handling of soiled laundry and the use of gloves to ensure policy and procedure is followed on 11/20/17. DNS/designee to conduct random visual audits relating to the transportation of dirty linen weekly on all shifts. Monitoring for Compliance DNS/designee will conduct weekly audits for four weeks and then every month for two months relating to observation of soiled linen handling and the use of gloves. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days. Results of the audits will be brought to monthly QAPI meeting for review and recommendation for 90 days.	