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 11/08/2018

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 11/5/18 through 11/8/18. Also reviewed in the course of the survey were complaint intakes WY00002548 and WY00002515. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status cm: Centimeter CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set mg: Milligram RN: Registered Nurse	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		11/12/18

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

Electronically Signed | 12/04/2018

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to issue the	F 582	This plan of correction is prepared and submitted as required by law. By	

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F 582	Continued From page 2 Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 3 sample residents (#63) reviewed with a Medicare Part A stay. The findings were: Review of a "SNF [skilled nursing facility] Beneficiary Protection Notification Review" form filled out by the facility showed resident #63 had a Medicare Part A episode starting on 6/16/18. Further review showed the last covered day of Part A services was 8/7/18. The form stated the facility initiated the discharge from Part A services before benefits were exhausted. The resident remained at the facility following the discontinuation of Part A services. Interview with the DON and the regional nurse on 11/6/18 at 5:37 PM revealed the resident was issued the "Notice of Medicare Non-coverage" form prior to Medicare Part A services ended, but was not issued the SNFABN form.	F 582	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 Re-educated Social Services Director on SNFABN requirements for Medicare covered stays on 11/12/2018. Identification of Others Audit of all eligible residents for the SNFABN notice was completed within the last 90 days. No other deficiencies were found. Systemic Changes Re-educated Social Services Director on SNFABN requirements for Medicare covered stays on 11/12/2018. On normal business days IDT will review upcoming discharges for notification having been completed in appropriately. Monitoring for Compliance During normal business days, ED and SSD will complete daily audit of residents less than one week from discharge from a Medicare covered stay for completion of ABN, if required for the next 90 days. Results of the audit will be brought to	

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F 582	Continued From page 3	F 582	monthly QAPI meeting for review and recommendation for 90 days.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		11/8/18

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F 623	Continued From page 4	F 623		

under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder

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F 623	Continued From page 5 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a notice of transfer prior to a facility-initiated hospital transfer for 2 of 2 sample residents (#59, #61) reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record showed resident #59 was transferred to the hospital on 9/15/18. Further review showed the facility did not issue a written transfer notice to the resident or the resident's representative at the time of the hospitalization. 2. Review of the nursing progress notes showed resident #61 was transferred to the emergency department for an acute illness on 10/14/18. Review of the medical record failed to show	F 623	Corrective Actions Educated all nurses on 11/06/2018 to give out transfer policy for each instance of transfer to hospital. Audit on 11/27/2018 shows that 100% of eligible discharges/transfers have been provided the transfer policy. Identification of Others Audit on 11/12/2018 showed 2 of 3 instances since 11/01/2018 that were not in compliance. Corrective action included re-education for all nurses to give out transfer policy in each instance of transfer to hospital. Systemic Changes	

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F 623	Continued From page 6 evidence a transfer notice was given to the resident or the resident's representative. 3. Interview on 11/8/18 at 9:23 AM with the DON revealed the facility had not issued a notice of transfer to the resident or the resident's representative.	F 623	SDC educated nurses to give transfer policy to resident or resident group before transfer on 11/06/2018. ED educated DON, SDC, RCM, MDS, and MR to ensure that transfer agreement being issued is included in nursing notes when transfer occurs on 11/27/2018. RCM compiled copies of transfer agreement at 2 of 2 nursing stations for immediate retrieval and use by nurses on 11/06/2018. Monitoring for Compliance ED, DON, or designee will audit each involuntary transfer or discharge for the next 90 days for appropriate issuance of transfer policy. All results will be brought and reviewed at the QAPI meeting for review, recommendations, and need for ongoing monitoring.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		11/8/18

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F 625	Continued From page 7 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review and staff interview, the facility failed to provide written information on the bed-hold policy for 2 of 2 sample residents (#59, #61) reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record showed resident #59 was transferred to the hospital on 9/15/18. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 2. Review of the medical record showed resident #61 was transferred to the emergency department for an acute illness on 10/14/18. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative. 3. Interview on 11/8/18 at 9:23 AM with the DON confirmed the facility had not issued written notices of the bed-hold policy to the resident or	F 625	Corrective Actions Educated all nurses on 11/06/2018 to give out bed hold agreement for each instance of transfer to hospital. Audit on 11/27/2018 shows that 100% of eligible discharges/transfers have been provided the bed hold agreement. Identification of Others Audit on 11/12/2018 showed 2 of 3 instances since 11/01/2018 that were not in compliance. Corrective action included re-education for all nurses to give out bed hold agreement in each instance of transfer to hospital Systemic Changes SDC educated nurses to give bed hold agreement to resident or resident group before transfer on 11/06/2018. ED educated DON, SDC, RCM, MDS, and MR to ensure that bed hold policy	

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F 625	Continued From page 8 the resident's representative. 4. Review of the Bed-Hold Policy, revised July 2014, showed "At transfer, the resident/responsible party receives a copy of the bed hold policy..."	F 625	being issued is included in nursing notes when transfer occurs on 11/27/2018. RCM compiled copies of bed hold agreement at 2 of 2 nursing stations for immediate retrieval and use by nurses on 11/06/2018. Monitoring for Compliance ED, DON, or designee will audit each involuntary transfer or discharge for the next 90 days for appropriate issuance of bed hold agreement. All results will be brought and reviewed at the QAPI meeting for review, recommendations, and need for ongoing monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (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	F 657		11/9/18

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F 657	Continued From page 9 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 observation, staff and family interview, and medical record review, the facility failed to ensure care plans were revised to address all current assessed needs for 3 of 22 sample residents (#11, #34, #62) reviewed for individualized plans of care. The findings were: 1. Review of the 8/15/18 care plan showed resident #11 required assistance with all activities of daily living; and had severe cognitive impairment, impaired thought processes, communication problems, and potential for chronic pain related to Alzheimer's disease. Interview on 11/5/18 at 4:31 PM with a family member revealed the resident complained about pain in his/her left arm that worsened when moved or repositioned. The family member stated an x-ray of the resident's arm showed no fractures, but the resident continued to complain of the pain. The family member also stated the resident had experienced pain due to arthritis in the past and it would be good if there was some way to prevent the pain when staff used the mechanical lift for transfers. During the interview, the resident was observed sitting in the wheelchair using his/her right arm to hold the left arm close to his/her stomach and performed continuous massaging motions on the left arm. On 11/7/18 at 4:38 PM interview with CNA #1	F 657	Corrective Actions: Care Plans for the identified residents #11, #62 have been revised on 11/28/18 by Kayla Schubach RN MDS; to address individualized care. Resident #34 has passed away; 11/16/18. Identification of Others Care Plans have been reviewed on 11/27/18 for all of the current residents, matching the care plan directives, to ensure individualized care. Systemic Changes All Licensed Nurses and IDT members have been educated on the Care Plan expectations ensuring they are individualized by Kerry Smrekar RN DNS on 11/9/18. Monitoring for Compliance New Admits will be reviewed in clinical meeting, at 72-hour meeting to ensure the care plan is individualized. LTC residents will be reviewed quarterly during their assessment and at any change of condition. In addition, the PCC Dashboard will be used to monitor daily (M-F), for upcoming Care Plan revisions to alert the	

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F 657	Continued From page 10 revealed direct care staff were aware of the resident's complaints about the pain in his/her left arm, but had not received any instructions about support/positioning techniques, pain medication prior to transfers, or specific interventions to address the pain. On 11/8/18 at 11:10 AM interview with the resident care manager revealed she knew the x-ray was negative and family reported the resident had arthritis. She stated the care plan interventions addressed pain, but did not include measures to alleviate the pain in the resident's arm because staff had not developed pharmacological or non-pharmacological interventions that specifically addressed arm pain. 2. Review of the 7/29/18 and 9/25/18 quarterly MDS assessment showed resident #34 was at risk for developing pressure ulcers, but did not have pressure ulcers. Review of the 10/14/18 Skin/Wound Note showed staff noted a pressure ulcer on the resident's left coccyx area measuring 1 cm by 0.5 cm with white edges and a superficial pink area in the center of the wound bed. Review of the 10/17/18 nutrition/dietary note showed the resident had a stage 2 pressure ulcer on the coccyx and the nutritional assessment was completed with no new nutritional recommendations at that time. Review of the 11/1/18 weekly skin evaluation showed the area measured 0.5 cm by 0.5 cm by 0.2 cm, with a pink/beefy red wound bed, peripheral tissue edema in the surrounding wound edges, and pink surrounding skin color. The following concerns were identified: a. On 11/6/18 at 11:16 AM LPN #1 was observed changing the dressing on the pressure ulcer. At that time, the stage 2 pressure ulcer was observed to be longer and wider than	F 657	IDT. Audits of Care Plans will be conducted by the MDS nurse or designee weekly X 4 weeks then Monthly X 2 Months, and results will be brought to the monthly QAPI. An AdHoc QAPI meeting was held on November 29, 2018 to discuss this POC and its adaptation.	

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F 657	Continued From page 11	F 657		

documented measurements for the previous week. Further observation showed the moist, and pinkish white wound bed was surrounded by an approximately 8 cm area of redness. Review of the weekly skin evaluation, dated 11/8/18, showed the area measured 1.1 cm by 1.5 cm by 0.2 cm with serosanguineous drainage and 50% granulation and slough.

b. Review of the care plan revised on 10/17/18 showed staff were directed to encourage good nutrition and hydration and reposition often. This review also showed these were the interventions prior to the development of the pressure ulcer, and were unchanged after the development of the pressure ulcer.

c. Review of the care plan showed comfort care interventions were added on 10/19/18. Review of the comfort care directive form showed it was developed on 10/26/18. Neither review showed evidence the interventions for "wound to coccyx" were assessed for effectiveness, and both directed staff to continue the same interventions that were implemented prior to the development of the pressure ulcer.

d. On 11/8/18 at 11:20 AM interview with the resident care manager revealed with the exception of the nutritional assessment and physician prescribed wound treatments; additional nursing care interventions to promote wound healing had not been developed.

3. Review of the 10/23/18 quarterly MDS assessment showed resident #62 had a staff determination for cognition as moderate independence with some difficulty; diagnoses which included Alzheimer's disease, dementia, anxiety disorder, and depression; and had no behaviors during the 7-day look-back period. Review of the October 2018 "Medication Review

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(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 657	Continued From page 12 Report" showed the physician had prescribed lorazepam (anti-anxiety) 0.5 mg 4 times a day PRN (as needed) for anxiety/agitation and trazodone (sedative and antidepressant) 100 mg every 8 hours PRN for anxiety/agitation with a start date of 10/18/18 for each medication. The following concerns were identified. a. Review of the care plan showed no evidence parameters had been defined as to when to administer each of the prescribed PRN medications. b. Interview with the DON on 11/7/18 at 11:58 AM revealed the facility's interdisciplinary team (IDT) and the nurses met at least monthly to discuss medications. It was at this meeting the resident's behaviors were discussed and parameters developed to define which medication was to be used for each behavior identified. Further, the DON confirmed the care plan had not been revised to reflect the decisions of the IDT.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		11/9/18

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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F 686	Continued From page 13 by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to provide care and services necessary to treat pressure ulcers for 2 of 4 residents (#34, #224) reviewed for pressure ulcers. The findings were: 1. Review of the 7/29/18 and 9/25/18 quarterly MDS assessment showed resident #34 was at risk for developing pressure ulcers, but did not have pressure ulcers. Review of the 10/14/18 Skin/Wound Note showed staff noted a pressure ulcer on the resident's left coccyx area measuring 1 cm by 0.5 cm with white edges; and a superficial pink area in the center of the wound bed. Review of the 10/17/18 nutrition/dietary note showed the resident had a stage 2 pressure ulcer on the coccyx and the nutritional assessment was completed with no new nutritional recommendations at that time. Review of the 11/1/18 weekly skin evaluation showed the area measured 0.5 cm by 0.5 cm by 0.2 cm, with a pink/beefy red wound bed, peripheral tissue edema in the surrounding wound edges, and pink surrounding skin color. The following concerns were identified: a. On 11/06/18 at 11:16 AM LPN #1 was observed changing the dressing on the pressure ulcer. At that time, the stage 2 pressure ulcer was observed to be longer and wider than documented measurements for the previous week. Further observation showed the moist and pinkish-white wound bed was surrounded by an approximately 8 cm area of redness. Review of the weekly skin evaluation dated 11/8/18 showed the area measured 1.1 cm by 1.5 cm by 0.2 cm with serosanguineous drainage and 50% granulation and slough.	F 686	Corrective Actions: Resident #34 has passed away on 11/16/18, therefore further assessments are not applicable. Resident #224 pressure ulcers have been monitored per the policy 11/09/18 by Kerry Smrekar RN DNS. Identification of Others Audit of all current residents was conducted on 11/16/18 by Kerry Smrekar RN DNS for skin impairments. Weekly Skin Evaluations per policy will be conducted by LN and reviewed by DNS. Systemic Changes All Licensed nurses were re-educated on 11/09/18 by Kerry Smrekar RN DNS, regarding the Skin Policy and Procedure to ensure understanding. Monitoring for Compliance Weekly skin evaluations will be conducted by the LN, reviewed by DNS and any impairments will be addressed per the policy & procedure. New Admits will be reviewed in clinical meeting to ensure any skin impairments are addressed per the policy and procedure, including measurements of size, color, presence of odor, including interventions. Weekly Audit X 4 weeks, then Monthly X 2 months, of Skin Evaluations on the MAR will be completed by DNS or designee to ensure the policy and procedure is followed including measurements of size, color, presence of odor, including	

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 14 b. Review of the care plan revised on 10/17/18 showed staff were directed to encourage good nutrition and hydration and reposition often. This review also showed these were the interventions prior to the development of the pressure ulcer and were unchanged after the development of the pressure ulcer. c. Review of the care plan showed comfort care interventions were added on 10/19/18. Review of the comfort care directive form showed it was developed on 10/26/18. Neither review showed evidence the interventions for "wound to coccyx" were assessed for effectiveness, and both directed staff to continue the same interventions that were implemented prior to the development of the pressure ulcer. d. On 11/8/18 at 11:20 AM interview with the resident care manager revealed with exception of the nutritional assessment and physician prescribed wound treatments; additional nursing care interventions for promoting wound healing for the pressure ulcer had not been developed. She further stated the resident needed increased fluids and frequent repositioning to promote wound healing, but a system for ensuring the resident received increased fluids and repositioning had not been implemented. e. Review of the policy and procedure for skin integrity, updated March 2018, showed for skin impairment noted after admission, the DON or designee would "complete a comprehensive review of the resident's medical record to evaluate if the pressure ulcer was avoidable or unavoidable. This evaluation is documented in the Nurse's Notes." Review of the October 2018 nurse's notes showed no evidence of the evaluation.	F 686	interventions. Results will be brought to the monthly QAPI meeting for review, recommendations and need for ongoing monitoring. An AdHoc QAPI meeting was held on November 29th, 2018 to discuss this POC and its adaptation.	

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 15 2. Review of the medical record showed resident #224 was admitted on 11/1/18 with diagnoses which included a pressure ulcer. Review of the nursing progress note dated 11/2/18 and timed 2:08 PM showed the resident had "approximately 3 stage 1 pressure sores to left buttock...". The following concerns were identified: a. Review of the Admission-Readmission Nursing Evaluation dated 11/1/18 showed the resident did not have a pressure ulcer. b. Review of the Weekly Skin Evaluation dated 11/2/18 showed the resident had a pressure sore on the buttock, but failed to show measurements. c. Review of the care plan dated 11/5/18 showed the resident had actual impairment to skin integrity and interventions included "monitor/document location, size and treatment of skin injury...." d. Interview with the DON on 11/7/18 at 3:04 PM confirmed the resident had a pressure ulcer. She further revealed the measurements would be located in the nursing progress notes, the nursing admission evaluation, and on the weekly skin evaluation. She further acknowledged the nursing documentation failed to show measurements of the pressure ulcer. e. Review of the Skin Integrity Policy, updated March 2018, showed interventions for pressure ulcers identified with admission were to "document skin impairment that includes measurements of size, color, presence of odor....in the nurses' notes and on the weekly wound evaluation...".	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		11/26/18

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 16 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure adequate hydration for 1 of 1 sample resident (#172) reviewed for hydration needs. The findings were: Review of the 11/2/18 physician admission orders for resident #172 showed staff were required to monitor fluid intake to ensure fluid intake was limited to 2000 cc every 24 hours. Review of the 11/3/18 care plan showed the resident did not have cognitive impairment and required limited assistance with transfers, toileting, and dressing. Further review showed s/he did not require assistance with eating and drinking. The following concerns were identified: a. During an interview on 11/6/18 at 9:10	F 692	Corrective Actions Monitoring/documentation of fluid restrictions was revised on 11/08/18. There are no Residents on a fluid restriction at this time including resident #172 who was removed form restriction on 11/15/18. Identification of Others Audit of all current residents was conducted for Fluid Restrictions on 11/28/18 by Lee Flynn LPN RCM. There are no Residents on a fluid restriction at this time including resident #172 who was removed form restriction on 11/15/18.	

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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F 692	Continued From page 17 AM the resident stated s/he understood why his/her medical condition required the physician to order restricted fluids; but his/her throat got so dry and it felt terrible to have such a dry mouth. b. Review of the fluid intake records showed the following amounts were consumed: 960 cc on 11/3/18, 480 cc on 11/4/18, 720 cc on 11/5/18, 840 cc on 11/6/18, refused water during day shift on 11/3/18, 11/4/18, 11/5/18 and refused fluids during evening hours on 11/6/18. c. Interview on 11/8/18 at 11:35 AM with the resident care manager and the DON revealed the restricted fluid monitoring system for the resident included a schedule for the amount of fluids allowed each meal, and the amounts were documented on the fluid intake records. They further stated the monitoring system needed to be revised to ensure the resident received 2000 cc daily because it did not address providing fluids at a later time when the resident did not drink the scheduled amount at mealtimes.	F 692	Systemic Changes All Licensed nurses were re-educated by Kerry Smrekar RN DNS on 11/09/18; on the Nutrition/Hydration Policy and Procedure to ensure understanding. All C.N.A's were educated by Kerry Smrekar RN DNS, on the expectations of fluid restrictions and documenting of such on 11/26/18. New Admits or any residents newly on fluid restriction's will be reviewed in clinical meeting (M-F) to ensure residents on fluid restrictions are addressed per the policy and procedure. Any residents on a fluid restriction will be monitored by the Registered Dietitian. Revised documentation will be used to ensure the restriction is being followed. Monitoring for Compliance Weekly Audit/ Monitoring of fluid restrictions by RCM or designee weekly X 4 weeks, then monthly X 2 months to ensure any residents on fluid restrictions are following the policy and procedure. Monthly review of Audit at QAPI meeting for review, recommendations and need for ongoing monitoring. An AdHoc QAPI meeting was held on November 29th, 2018 to discuss this POC and its adaptation.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		11/30/18

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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F 697	Continued From page 18 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, and medical record review, the facility failed to ensure interventions for pain were effective for 3 of 6 sample residents (#5, #11, #124) reviewed for pain. The findings were: 1. Review of the 8/15/18 care plan showed resident #11 required assistance with all activities of daily living and had severe cognitive impairment, impaired thought processes, communication problems, and potential for chronic pain related to Alzheimer's disease. Interview on 11/5/18 at 4:31 PM with a family member revealed the resident complained about pain in his/her left arm that worsened when moved or repositioned. The family member stated an x-ray of the resident's arm showed no fractures, but the resident continued to complain of the pain. The family member also stated the resident had experienced pain due to arthritis in the past and it would be good if there was some way to prevent the pain when staff used the mechanical lift for transfers. During the interview, the resident was observed sitting in the wheelchair using his/her right arm to hold the left arm close to his/her stomach and performed continuous massaging motions on the left arm. The following concerns were identified: a. Interview on 11/5/18 at 4:05 PM with LPN #1 revealed staff were aware of the resident's complaints about the pain in his/her left arm; but the x-rays showed the resident did not have a fracture. She further stated the resident's family mentioned something about arthritis, however she was not aware of any follow up care	F 697	Corrective Actions: Immediate review of Pain Monitoring for #5, #11, #124 on 11/26/18, including an interview with residents (or POA) to determine they are satisfied with their current prescribed regiment as well as education to the Resident and POA the interventions that are available to them for pain. It was noted on these interviews residents were satisfied with their current treatments. All nursing staff was immediately educated by Peggy Doty LPN SDC on 11/09/18 regarding the documentation requirements when administering pain interventions to including follow up efficacy. Identification of Others All Residents received a new pain evaluation and review of prescribed current pain interventions to ensure they are satisfied with their plan of care regarding pain on 11/29/18 by Kerry Smrekar RN DNS. Systemic Changes A pain subcommittee IDT was formed to review and make recommendation for those residents stating they have moderate to severe pain upon admission, MDS assessments, and per nurse□s referral to review. The subcommittee will meet weekly to review and implement interventions for pain relief as needed for	

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F 697	Continued From page 19 that had been implemented to address it. b. Observation on 11/7/18 at 11:45 AM showed CNA #2 and CNA #1 used a mechanical sit-to-stand lift to transfer the resident from the recliner chair to the bathroom. During the observation, the resident held his/her left arm with the right arm; and cried out in pain when the CNAs gently moved the resident's left arm to the support bar on the lift. Continued observation showed throughout the interaction the resident used his/her right arm to support and protect the left arm and repeatedly stated "my arm hurts". c. On 11/7/18 at 4:38 PM interview with CNA #1 revealed direct care staff were aware of the resident's complaints about the pain in his/her left arm; but they had not received any instructions about support/positioning techniques, pain medication prior to transfers, or specific interventions to address the pain. d. Review of the November 2018 MAR showed scheduled Tylenol extra strength 500 mg for pain 1-2 pills three times daily was ordered on 9/11/2018. This review showed no additional pharmacological, and no non-pharmacological interventions for arm pain. e. On 11/8/18 at 11:10 AM interview with the resident care manager revealed she knew the x-ray was negative and family reported the resident had arthritis. She stated the care plan interventions addressed pain, but did not include measures to alleviate the pain in the resident's arm because staff had not developed pharmacological or non-pharmacological interventions that specifically addressed arm pain. 2. Review of the 10/31/18 admission MDS assessment showed resident #124 was admitted to the facility on 10/24/18, had a BIMS score of	F 697	those residents identified to be at risk. All nurses were re-educated on the facility pain management policy and procedure on the 11/09/18 by Kerry Smrekar RN DNS. Monitoring for Compliance Audits have been completed by RCM Lee Flynn LPN, and Kerry Smrekar RN DNS on 11/09/18; 11/16/18; 11/21/18; 11/29/18. Audits will be conducted weekly X 12 weeks. Results of the audits will be brought to the Monthly QAPI meeting for review, recommendations and need for ongoing monitoring. As AdHoc QAPI meeting was held on November 29th, 2018 to discuss this POC and it adaptation.	

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F 697	Continued From page 20	F 697		

15/15 (cognitively intact), and had a diagnosis of Herpes zoster eye disease (shingles in the eye). Interview with the resident on 11/6/18 at 11:42 AM revealed s/he had pain which radiated through his/her eye and sometimes down his/her nose. Observation at that time showed the resident was rubbing his/her head and grimacing. Review of the current physician's orders showed the resident was prescribed Percocet (a narcotic for pain) 5/325 mg every 4 hours as needed for a pain level of 7-10 (pain scale of 0-10 with 0 meaning no pain and 10 meaning worst possible pain) and Tylenol 325 mg 2 tablets every 6 hours as needed for a pain level of 1-3. Gabapentin (medication for nerve pain) 100 mg 2 capsules 3 times a day was also prescribed. Review of the admission pain evaluation dated 10/24/18 showed the resident had mild to moderate pain which was made worse by "lack of pain medications." The following concerns were identified:

a. Review of the physician's orders showed no evidence of treatment parameters for a pain level of 4-6.

b. Review of the October 2018 MAR showed the resident was given Tylenol twice on 10/25 and twice on 10/26. Review of the pain management flowsheet showed no documentation the medication had been administered or the effectiveness determined.

c. Review of the October 2018 pain management flowsheet showed the resident had a pain level of 7 on 10/29/18 at 8:50 AM and again on 10/30/18 at 6:42 AM. The resident was given 650 mg of Tylenol. The "Follow-up evaluation of intervention and/or discomfort" showed the pain level remained at a 7. The non-medication intervention was noted as "decrease environmental stimulation".

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 21	F 697		

d. Review of the October 2018 MAR showed Percocet was given twice on 10/31/18. Review of the pain management flowsheet showed no documentation the medication had been administered or the effectiveness determined.

e. Review of the November 2018 MAR showed Percocet was given on 11/3 at 6:30 PM; 11/4 at 6:27 AM; 11/5 at 11 AM; and 11/6 at 1:28 PM. Review of the pain management flowsheet showed no documentation the medication had been administered or the effectiveness determined.

3. Review of the 11/1/18 quarterly MDS assessment showed resident #5 had a BIMS score of 12/15 (moderate cognitive impairment) and was coded as having frequent, mild pain. Review of a physician order showed the resident was prescribed tramadol HCl (narcotic to treat moderate to severe pain) 50 mg as needed three times a day for neck pain. The following concerns were identified:

a. Review of the October 2018 "Pain Management Flowsheet" showed no documentation the medication had been evaluated for effectiveness 4 of the 12 times the tramadol was administered.

b. Review of the November 2018 MAR showed the resident was administered tramadol 12 times. Review of the pain management flowsheet showed no documentation the medication had been administered or effectiveness determined for 8 of the 12 times the medication was administered.

4. Interview with the DON on 11/7/18 at 2:25 PM revealed the nurses should have been more "mindful" of the time and administered the Percocet instead of the Tylenol to resident #124.

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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F 697	Continued From page 22 In an additional interview on 11/8/18 at 12:33 PM the DON confirmed the pain management flowsheets were not complete.	F 697		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		11/9/18

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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 758	Continued From page 23 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 4 of 5 sample residents (#5, #28, #54, #62) reviewed for medications. The findings were: 1. Review of the psychotropic drug and behavior review form for resident #54 showed Haldol (antipsychotic) and Zyprexa (antipsychotic) were ordered for dementia with behaviors. Review of the physician's orders showed Haldol 0.5 mg every 8 hours as needed, was ordered on 10/10/18, and Zyprexa 0.5 mg every 12 hours as needed was ordered on 10/16/18. Further review of the orders showed a stop date had not been included in the order or a rationale for extending the use beyond 14 days. On 11/7/18 at 2:17 PM, interview with the DON confirmed the orders for PRN antipsychotic medications were not limited to 14 days. 2. Review of the September 2018 monthly	F 758	Corrective Actions Resident #54 Haldol was discontinued 11/07/18. Zyprexa was discontinued on 11/13/18. No further PRN's are ordered. Resident #28 Risk verses benefit statement obtained via Primary Care Physician on 11/28/18. Resident #5 Behavioral Monitoring Flowsheet was updated on 11/29/18 by Kayla Schubach RN MDS with both Target Behaviors and interventions for each of the medications Resident #5 is taking. Resident #62 The Care Plan and Behavioral Monitoring Flowsheet were updated, on 11/29/18 by Kayla Schubach RN MDS with both Target Behaviors and Interventions for each of the medications Resident #62 is taking. Identification of Others Audit of all Behavioral Monitoring Flowsheets on 11/27/17 by Kerry Smrekar RN DNS; of residents who are	

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 11/08/2018

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

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F 758	Continued From page 24 pharmacy review form for resident #28 showed the resident was due for an annual dose reduction assessment for daily doses of Ativan (anti-anxiety), Prozac (antidepressant), Remeron (antidepressant) and Abilify (used for treating conditions such as depression, schizophrenia and bipolar disorder). Review of the physician's response, dated 9/11/18, showed he agreed to a reduction in the Prozac; but did not address the request for the dose reduction assessments for the Ativan, Remeron, and Abilify. On 11/8/18 at 9:25 AM interview with the resident care manager revealed the gradual dose reduction assessments had not been addressed because the recently hired social services staff was currently learning how to track due dates for gradual dose reduction medications and the nursing staff needed additional education regarding behavior documentation. 3. Review of the 11/1/18 quarterly MDS assessment showed resident #5 was admitted to the facility on 3/1/18 and had diagnoses which included depression, non-Alzheimer's dementia and Alzheimer's disease. Further review showed the resident had a BIMs score of 12/15 (moderate cognitive impairment), wandered daily, and had a mood score of 0/27. Review of the current physician's orders showed the resident was prescribed citralopram hydrobromide (antidepressant) 20 mg daily for depression; quetiapine fumarate (antipsychotic) 25 mg tablet twice daily for dementia with behavioral disturbances; and quetiapine fumarate 25 mg 3 tablets at bedtime for agitation. Review of the behavior care plan last revised 8/22/18 showed the resident had the potential to be physically aggressive by pushing, shoving, and making false accusations. Triggers included "thinking that	F 758	administered Psychotropic Medications to ensure Both Target Behaviors and Interventions for each medication any discrepancies found were corrected immediately. Systemic Changes All Licensed nurses were re-educated by Kerry Smrekar RN DNS on the Psychotropic Policy and Procedure to ensure understanding, on 11/9/18. Residents with Psychotropic Medications will be reviewed weekly at the Psychotropic Monitoring meeting and once per month with the Pharmacist to ensure that the behavioral monitoring sheets have target behaviors and interventions that are in-line with the Psychotropic medications they are administered. Monitoring for Compliance Audit of Behavioral Monitoring sheets will be completed by SSD or designee: Weekly X 4 weeks then Monthly X 2 months to ensure the policy and procedure is followed including Interventions. Results will be reviewed at monthly QAPI for review, recommendations and need for ongoing monitoring. An AdHoc meeting was held on November 29th, 2018 to discuss this POC and its adaptation	

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 11/08/2018

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

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F 758	Continued From page 25	F 758		

someone is taking [his/her] items" with interventions of redirection and reassurance. The depression care plan last revised 10/22/18 showed the resident had episodes of crying. The following concerns were identified:

a. Review of the "12-hour Shift Behavior Monitoring Flowsheet" showed a behavior of crying related to depression was to be monitored with no triggers or interventions defined. Further review showed the monitoring flowsheet did not include specific target behaviors, triggers, or interventions identified for the use of each individual medication.

4. Review of the 10/23/18 quarterly MDS assessment showed resident #62 was admitted on 1/9/18; had a staff determination for cognition as moderate independence with some difficulty; diagnoses which included Alzheimer's disease, dementia, anxiety disorder, and depression; and had no behaviors during the 7-day look-back period. Review of the October 2018 "Medication Review Report" showed the physician had prescribed lorazepam (anti-anxiety) 0.5 mg 4 times a day PRN (as needed) for anxiety/agitation and trazodone (sedative and antidepressant) 100 mg every 8 hours PRN for anxiety/agitation with a start date of 10/18/18 for each medication. In addition, Paxil (antidepressant) 30 mg 0.5 tablet in the morning for depression with a start date of 10/17/18, and Seroquel (antipsychotic) 25 mg 3 tablets daily at bedtime for dementia with behaviors with a start date of 9/19/18 were ordered. Review of the depression care plan last revised 11/7/18 showed the resident had episodes of agitation and the PRN lorazepam was used for signs and symptoms of anxiety including pacing, restlessness, standing up, sitting down, and hand wringing. Review of the

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 11/08/2018

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

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F 758	Continued From page 26 behavior care plan last revised 9/17/18 showed the resident was prescribed an antipsychotic related to the "potential for injury to self or others." The following concerns were identified. a. Review of the "12-hour Shift Behavior Monitoring Flowsheet" showed a behavior of physical aggression towards staff and residents; a trigger of increased anxiety; interventions of 1 to 1 direct care, redirection, and to provide other activities. Further review showed the monitoring flowsheet did not include specific target behaviors, triggers, or interventions identified for the use of each individual medication. b. Review of the September 2018 MAR showed lorazepam was administered on 7 days and trazodone was administered on 9 days during the month. Review of the behavior monitoring flowsheet showed the resident had behaviors documented on 3 days in September. c. Review of the October 2018 MAR showed trazodone was administered on 2 days during the month. Review of the behavior monitoring flowsheet showed the resident had not had any behaviors documented during the month of October. 5. Interview with the DON on 11/7/18 at 3:26 PM confirmed the behavior monitoring flowsheets were not specific to each medication prescribed. In an additional interview on 11/8/18 at 12:33 PM the DON confirmed the behavior monitoring flowsheets were incomplete.	F 758		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and	F 775		11/9/18

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 11/08/2018

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

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F 775	Continued From page 27 address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to file laboratory reports in the medical record for 1 of 2 sample residents (#35) reviewed for laboratory results. The findings were: Review of the medical record for resident #35 showed a urinalysis with culture and sensitivity if indicated was ordered on 8/7/18. Further review of the medical record showed the urinalysis report was indicative of a urinary tract infection; however the medical record showed no evidence of the culture and sensitivity report. Interview with the infection preventionist on 11/8/18 at 11:26 AM confirmed the laboratory report was not in the resident's chart.	F 775	Corrective Actions Resident #35 Laboratory Result/Cultural and Sensitivity was placed in the medical record on 11/08/18. Identification of Others Audit of all residents that had Lab work ordered was conducted on 11/16/18 by Peggy Doty LPN SDC. All lab results were confirmed to be in the medical record. Systemic Changes All Licensed nurses were re-educated on the Laboratory Policy and Procedure 11/09/18 by Kerry Smrekar RN DNS to ensure understanding. Re-education to Medical Records by Kerry Smrekar RN DNS to ensure Lab work is in the medical record on 11/28/18. Monitoring for Compliance Residents with ordered lab work will be Audited weekly by Infection Preventionist, to ensure the results are entered in the Medical File. The “Lab Book” will be brought in to the am clinical meeting so the IDT and Infection Preventionist, can review the ordered lab work and check it against the medical record. Audit of completed Lab Work will be Audited by Infection Preventionist or designee weekly X 4 weeks then Monthly X 2monhts to ensure the policy and procedure is followed. Results will be reviewed at monthly QAPI meeting for review, recommendations and	

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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

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F 775	Continued From page 28	F 775	need for ongoing monitoring. An AdHoc QAPI meeting was held November 29th, 2018 to discuss the POC and its adaptation.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		11/9/18

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 11/08/2018

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

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F 791	Continued From page 29 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure dental services were provided for 1 of 1 sample resident (#69) reviewed for dental service needs. The findings were: Interview on 11/5/18 at 3:40 PM with resident #69 revealed the resident did not have teeth because s/he "could not afford it." The resident also stated the lack of teeth prevented him/her from eating some desired foods. Observation during the interview showed the resident was edentulous. Review of the 8/11/18 and 10/28/18 quarterly MDS admission assessments showed the resident was admitted on 5/18/18, had a BIMS score of 12/15 (moderate cognitive impairment), and did not have significant weight loss or swallowing difficulties. Interview on 11/7/18 at 12:15 PM with social services revealed dental needs were usually discussed at the monthly meeting, but it had not been discussed for this resident. He further stated addressing the resident's dental needs "fell through the cracks."	F 791	Corrective Actions Resident (#69) was given an explanation of her financial resources in which to pay for the dental services on 11/7/18 by SSD and BOM. The facility is actively seeking an appointment for #69. Identification of Others The facility is actively seeking an appointment for #69. No other Residents were identified in need of an appointments at that time. Systemic Change All Licensed nurses were re-educated on the Dental Policy and Procedure on 11/09/18; by Kerry Smrekar RN DNS, to ensure understanding. All nurses were re-educated 0n 11/09/18; by Kerry Smrekar RN DNS to identify the dental needs during the weekly skin assessment and the expectation to communicate any dental issues to SSD and Scheduler. Re-education to Social Services Director on 11/28/18; by Kerry Smrekar RN DNS to ensure the understanding of the Policy and Procedure of Dental.	

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 11/08/2018

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

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F 791	Continued From page 30	F 791	Re-education to Transportation/Schedule Audit on 11/28/18; by Kerry Smrekar RN DNS to ensure understanding of the time-frame in which to make appointments for dental. Monitoring for Compliance Audit of all residents via skin assessments that may need dental services on 11/16/18 by Kerry Smrekar RN DNS. Audits will be conducted weekly X 4 weeks, then monthly X 2 months. Audit results will be reviewed at monthly QAPI meeting for review, recommendations and need for ongoing monitoring. An AdHoc QAPI meeting was held on November 29th, 2018 to discuss this POC and its adaptation.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-	F 801		12/6/18

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 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 801	Continued From page 31 (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or	F 801		

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

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

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F 801	Continued From page 32 (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the enrollment letter, the facility failed to ensure the dietary manager was qualified. The facility census was 74. The findings were: Interview with the dietary manager on 11/8/18 at 11:15 AM revealed he was enrolled in the "Nutrition & Foodservice Professionals Training Course" through the University of North Dakota, but failed to complete the course by the 10/11/18 scheduled completion date. He also stated he had been granted an extension with a completion date of 4/11/19. Review of the enrollment letter showed the extended completion date was 4/11/19.	F 801	Corrective Actions Certified Dietary Manager started as Food and Nutrition services manager on 12/06/2018. Identification of Others No residents identified at risk. Systemic Changes Certified Dietary Manager started as Food and Nutrition Services Manager on 12/06/2018. Monitoring for Compliance ED to notify QAPI committee of Dietary Manager designation at next QAPI meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/9/18

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 11/08/2018

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

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F 880	Continued From page 33	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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;

§483.80(a)(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 resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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 11/08/2018

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 880	Continued From page 34 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, policy and procedure review, and staff interview, the facility failed to ensure effective infection control practices were followed during 4 random observations. The findings were: 1. Observation of medication pass on 11/5/18 at 4:44 PM showed RN #1 removed two pills, Plavix (blood thinner) and Proscar (urinary retention medication), from the medication pack, placed them into her hand and then transferred them into the medication cup. Further observation showed she administered the medications to the resident.	F 880	Corrective Actions The gown in the laundry area was removed and destroyed, therefore no longer in use. Identification of Others All Licensed Nurses were observed administering medications upholding the Policy and Procedure by Kerry Smrekar RN DNS on random dates. All staff were re-educated on the Personal Appearance and Dress Code 0n 11/29/18 by Kerry Smrekar RN DNS. All Staff were	

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	535031	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 2. Observation on 11/6/18 at 4:53 PM and on 11/8/18 at 10:08 AM showed RN #2 and RN #1 wore dangling earrings. 3. Observation on 11/8/18 at 9:17 AM in the laundry room showed a fluid resistant gown with a strip of 2-inch wide blue masking tape covering the seam of the gown's sleeve. Interview with the housekeeping supervisor on 11/8/18 at 9:49 AM revealed she had used tape on the sleeve of the gown because the seam had pulled apart. She had been using this gown to sort laundry because it was smaller than the other gowns available. In addition she stated she continued to use the gown because she was unable to find a replacement that was the correct size. 4. Interview on 11/8/18 at 8:36 AM with the DON and the infection preventionist revealed it was the expectation medications be directly transferred into a medication cup from the medication pack and not into the nurse's hand as this was inappropriate and unsanitary. In addition the DON confirmed she had noticed the dangling earrings; knew they were not appropriate, but had not addressed the issue with staff. 5. Interview with the DON on 11/8/18 at 12:43 PM confirmed the appropriate personal protective equipment should be worn when sorting contaminated laundry. 6. Review of the "Personal Appearance and Dress Code" policy last updated April 2007 revealed "...6. Excessive jewelry is not permitted where it may interfere with direct resident care or become a safety/infection control hazard. In such situations dangling earrings are not allowed..."	F 880	observed for adherence to the Dress Code/ Personal Appearance Policy and Procedure by random observation by Kerry Smrekar RN DNS & Peggy Doty LPN SDC/IP. All staff were re-educated on use of PPE on 11/09/18 by Kerry Smrekar RN DNS. All staff were observed for adherence to the use of PPE by random observations by Kerry Smrekar RN DNS-Peggy Doty LPN SDC/IP. Systemic Changes Re-education to staff of Dress Code Policy and use of PPE on 11/09/18 Kerry Smrekar RN DNS. All Licensed Nurses were re-educated on Medication Administration Policy and Procedure on 11/09/18 by Kerry Smrekar RN DNS. Direct Observation of Medication Administration by Kerry Smrekar RN DNS on various dates/times of administrations. Infection Preventionist and Housekeeping Manager will do Environmental Rounds weekly/randomly to ensure the use of PPE and Dress Code Policy and Procedure are being adhered to. Monitoring for Compliance Weekly Environmental rounds to be conducted by IP and Housekeeping Manager results of all audits to be brought to monthly QAPI for review, recommendations and need for ongoing monitoring. An Adhoc QAPI meeting was held on November 29th, 2018 to discuss the POC and its adaptation.	

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 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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