DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9060	A. BUILDING _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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

An initial certification survey was conducted by Healthcare Licensing and Surveys from 10/10/22 to 10/13/22.

The following common abbreviations are used throughout this document:

CNA- Certified Nurse Aide
DON- Director of Nursing
MDS- Minimum Data Set

Less commonly used abbreviations will be annotated in each deficiency.

F 623 SS=D 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

F 000 This plan of correction and the responses to each F-tag are submitted to maintain certification in the Medicare Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.

F-623 SS=D
Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

This REQUIREMENT is not met as evidenced by:
F 623 Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer for 1 of 1 sample residents (#57) reviewed for facility-initiated transfers.

Corrective Actions:
R#57 was mailed the Notice of Transfer/Discharge notification form on 11/2/22, relative to her emergent transfer to the hospital on 9/11/2022. These forms were uploaded into the EHR on 11/3/22.

The facility has reviewed all other resident records and no other residents were affected by this practice.

The facility has reviewed the policy and processes related to Notice Requirements before Transfer/Discharge.

The Nursing Home Administrator and/or designee for the facility has put a system in place to send the notice of transfer/discharge to the resident representative upon transfer. The resident representative will be notified verbally by nursing prior to the transfer and then sent a physical copy of the forms.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine Szymanski	SNF Administrator	11/07/2022

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 623	Continued From page 1 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, 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	F 623	Nursing staff will provide copies of the notices to the records department to be maintained in the EHR. As a back-up. the social worker will follow up with nursing on the next business day to ensure the forms were sent. Staff involved in this process were re-educated as to their respective roles and responsibilities. Monitoring and Tracking. Responsible Person(s): The Nursing Home Administrator and/or designee will review all discharges for alignment with the approved policy and process related to Notice Requirements before Transfer/Discharge for 4 weeks. Action will be taken immediately as issues are identified and staff education and coaching will be provided. Audit results and actions taken will be reported by the Nursing Home Administrator to the QAPI Committee and the Committee's recommendations will be followed for three months.	11/27/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 623	Continued From page 2	F 623		

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 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, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer for 1 of 1 sample residents (#57) reviewed for facility-initiated transfers. The findings were:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 3	F 623		

1. Review of the medical record showed resident #57 was transferred to the hospital on 9/11/22. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative.

2. Interview with the administrator and DON on 10/13/22 at 9:41 AM confirmed the facility did not send written transfer notices to the resident or resident's representative.

3. Review of the policy titled "Transfer or Discharge; Notice of; Appealing and Emergency Discharge" dated 3/31/22 showed "...Emergency Discharge or Transfer...When a resident is temporarily transferred on an emergency basis to an acute care facility the Nurse or Social Worker will provide an Immediate Notice of Transfer or Discharge to the resident and family member or legal representative as soon as practicable..."

F 625 SS=D 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

F-625 SS=D
Notice of Bed Hold Policy Before/Upon Transfer
CFR(s): 483.15(d)(1)(2)

This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of the bed-hold policy for 1 of 1 sample residents (#57) reviewed for facility-initiated transfers.

Corrective Actions:
R#57 was mailed the Bed Hold notification form on 11/2/22, relative to her emergent transfer to the hospital on 9/11/2022. These forms were uploaded into the EHR on 11/3/22.

The facility has reviewed all other resident records and no other residents were affected by this practice.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 625	Continued From page 4 (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, staff interview, and policy and procedure review, the facility failed to provide a written notice of the bed-hold policy for 1 of 1 sample residents (#57) reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record showed resident #57 was transferred to the hospital on 9/11/22. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Interview with the administrator and DON on 10/13/22 at 9:41 AM confirmed the facility did not send a written notice of the bed-hold policy to the resident or resident's representative. 3. Review of the facility policy titled "Bed Hold and Return" dated 3/31/22 showed "...1...a. When hospital transfers occur, the Social Worker (or nurse if Social Worker is unavailable) will provide the resident and/or resident representative a copy of the bed-hold form. b. For an emergency	F 625	The Nursing Home Administrator and/or designee for the facility has put a system in place to send the bed hold notification form to the resident representative upon transfer. The resident representative will be notified verbally by nursing prior to the transfer and then sent a physical copy of the forms. Nursing staff will provide copies of the notices to the records department to be maintained in the EHR. As a back-up, the social worker will follow up with nursing on the next business day to ensure the forms were sent. Staff involved in this process were re-educated as to their respective roles and responsibilities. 11/27/2022 Monitoring and Tracking and Responsible Person(s): The Nursing Home Administrator and/or designee will review all discharges for alignment with the approved policy and process related to Notice of Bed Hold Policy Before/Upon Transfer for 4 weeks. Action will be taken immediately as issues are identified and staff education and coaching will be provided. Audit results and actions taken will be reported by the Nursing Home Administrator to the QAPI Committee and the Committee's recommendations will be followed for three months.	

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F 625 Continued From page 5

hospital transfer, a copy of the bed-hold form will be sent with the resident and a copy for the resident representative will be sent the next business day..."

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 625

F-758 SS=E
Free from Unnec Psychotropic Meds/PRN Use
F 758 **CFR(s): 483.45(c)(3)(e)(1)-(5)**

This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure appropriate monitoring and interventions were in place for 2 of 5 sample residents (#51, #53) reviewed for unnecessary medications.

Corrective Actions:
For Residents #51, and #53 , the facility implemented a Psychotropic Drug Performance improvement Plan (PIP) to facilitate the correct use of psychotropic medications and has completed the following steps for residents on 11/5/22.
a) The providers and pharmacy have completed new orders requiring documentation with each administration of these medications to determine each of these areas.
b) The nursing supervisors have created resident-focused care plans to capture non-pharmacological interventions, behaviors, and the effectiveness of medical interventions.

The facility has reviewed all other resident's records that may also be affected by this practice by having the pharmacy team and providers review resident medication orders, and revise if applicable, to follow the Psychotropic Drug PIP identified for SNF by 11/5/22.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 6 §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, staff interview, and review of policy and procedure, the facility failed to ensure appropriate monitoring and interventions were in place for 2 of 5 sample residents (#51, #53) reviewed for unnecessary medications. The findings were: 1. Review of the 6/21/22 significant change MDS assessment showed resident #51 had diagnoses which included non-Alzheimer's dementia and schizophrenia. Further review showed the resident reported feeling bad about self and trouble concentrating half or more of the last 14 days, and included little interest or pleasure in doing things and feeling depressed or hopeless nearly every day. Behavioral symptoms included verbal threatening, screaming and cursing at others 4 to 6 days out of 7 days. Review of physician orders for October 2022 showed the resident received olanzapine (anti-psychotic) 5 mg (milligrams) by mouth daily at bed time for schizophrenia, and clonazepam (anti-anxiety) 0.5	F 758	The DON and/or designee have reviewed and revised the facility processes related to unnecessary medications including: 1. When receiving reports of medical intervention needs, the providers will notify nursing leadership to create "at-risk" care plans, which will include behavioral and symptomatic documentation related to frequency, duration, and non-pharmacological interventions used prior to the medication order; 2. the nursing leadership team will monitor care plans, and provide real-time feedback to providers regarding documentation collected by the at-risk care plans during routine clinical stand up meetings; and 3. the pharmacy team will provide the providers with medications that address those resident-specific needs. Monitoring and Tracking and Responsible Person(s): The IDT will monitor the effectiveness of the medications and interventions. During the Behavior Medication Review Committee (BMRC) and Drug Regimen Review (DRR), the medications management team and behavioral support will evaluate the medication and determine if an increase or decrease is warranted, based upon clinical standards. The BMRC review is completed quarterly to ensure that performance is sustained after implementation. The DRR is completed monthly to ensure that performance is sustained after implementation resident-specific needs. The DON and/or designee will monitor the PIP weekly for adherence to the policy and processes set forth, including input from the IDT, for 30 days. Action will be taken immediately as issues are identified and staff education and coaching will be provided. Audit results and actions taken will be reported by the Director of Nursing to the QAPI Committee for 3 months.	11/27/2022

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F 758	Continued From page 7	F 758		

mg by mouth twice a day for anxiety.

a. Review of the "Care Plan Report" last revised 7/8/22 showed no evidence of identified target symptoms, non-pharmacological interventions, or monitoring related to the use of psychotropic medications.

b. Review of the medication administration records (MAR) and treatment administration records (TAR) for August 2022, September 2022, and October 2022 showed no evidence of identified target symptoms, non-pharmacological interventions, or monitoring for the use of psychotropic medications.

2. Review of physician orders for October 2022 showed resident #53 had orders for quetiapine (anti-psychotic) 125 mg via g-tube (gastrostomy tube, a type of feeding tube) every day at bedtime for major depressive disorder and unspecified intracranial injury with loss of consciousness, and escitalopram (anti-depressant) 20 mg by mouth every day in the morning for major depressive disorder. Further review showed the resident had diagnoses which included intracranial injury with loss of consciousness, major depressive disorder, epilepsy and epileptic syndromes with complex partial seizures, and dysphagia. Review of the care plan last revised 7/11/22 showed "problems" which included "Behavioral Symptoms: [Resident] has displayed disruptive verbal aggression towards residents and staff. [Resident] has displayed disruptive physical behavior in banging on tables and other objects. [Resident] has displayed frustration by removing [his/her] feeding tube because [s/he] cannot eat orally." Interventions included "gently remind [resident] that screaming/ cursing is not appropriate. Record behaviors on Behavior

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F 758	Continued From page 8	F 758		

tracking Form. Monitor pattern of behavior (time of day, precipitating factors, specific staff or situations)." The following concerns were identified:

a. Review of the care plan last revised 7/11/22 showed no evidence of psychotropic medication use or target symptoms for individual psychotropic medication use.

b. Review of the MAR and TAR for August 2022, September 2022, and October 2022 showed no evidence of identified target symptoms, non-pharmacological interventions, or monitoring for the use of psychotropic medications.

c. Review of the "caregiver documentation" between 9/1/22 and 10/13/22 showed "Mood/Behavior Monitor...No Mood/Behavior Monitoring to Display."

3. Interview with the DON and administrator on 10/13/22 at 9:36 AM revealed staff were not required to document target symptoms, non-pharmacological interventions, or monitoring for the use of psychotropic medications. Further they confirmed the facility had not identified target symptoms for the use of the medications.

4. Review of the policy titled "Psychotropic Medication Use" dated 4/1/22 showed "...1. Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The medical provider and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others..."

F 880 Infection Prevention & Control — F 880

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F 880 SS=D	Continued From page 9 CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	**F-880 SS=D Infection Prevention & Control CFR(s): CFR(s): 483.80(a)(1)(2)(4)(e)(f)**	

§483.80 Infection Control
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

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and policy and procedure review, the facility failed to ensure appropriate infection control techniques were implemented to prevent cross contamination during 1 random observation. The census was 8.

Corrective Actions:
Resident #53 shows no signs of infection.

CNA's #2 and 3 have been provided hands-on training and follow-up observations beginning on 11/1/2022. This training includes spot-checking perineal care by the RN to verify the accuracy of hand hygiene and procedure compliance.

All staff were educated on proper hand hygiene procedures in accordance with the current CDC and CMS guidelines. The facility has completed hands-on training for all CNAs (completed by registered nurses) by 11/11/2022. The facility will train the entire CNA staff on perineal care and provide additional continuing education training via Lippincott to prevent other residents from being affected by this deficiency. Lippincott assignments were sent out on 11/1/2022, with a completion date required of 11/27/2022. The hands-on training was assigned on 11/1/2022, with a completion date required of 11/11/2022.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9060	A. BUILDING _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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 880	Continued From page 10 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. §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, staff interview, and policy and procedure review, the facility failed to ensure appropriate infection control techniques were implemented to prevent cross contamination during 1 random observation. The census was 8. The findings were: 1. Observation on 10/12/22 at 11:13 AM showed CNA #2 and CNA #3 assisted resident #53 to his/her room. The CNAs performed hand hygiene	F 880	The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, have: • Identified and implemented hand hygiene procedures, for staff and residents, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). • The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from the CDC and CMS. • The IP, DON, and applicable IDT members will monitor and evaluate the facility's overall compliance with the guidelines. Based upon outcomes identified, the facility will develop action plans to address any newly identified non-compliance. The DON, IP, and applicable IDT members have conducted a root-cause analysis to identify and address the reasons for non-compliance related to hand hygiene being performed in accordance with current guidance after contact with blood, body fluids, or visibly contaminated surfaces and after the removal of personal protective equipment (PPE). Weekly monitoring will be completed, as well as spot checks by the nursing department and infection prevention (IP) nurse for 12 weeks starting 11/18/2022, to determine compliance with hand hygiene during resident care and hand hygiene before and after the use of PPE. Deficient practices will be immediately corrected, retrained, and tracked on monthly rounds sheets kept by the Infection Preventionist RN. After 12 weeks, if monitoring demonstrates expectations are met, it will be reduced to monthly for at least 3 months. To increase the sustainability of this plan of correction, the DON has increased the routine CNA competency check-off to quarterly, rather than annually. This will be tracked and monitored by the DON, and Nurse Educator for compliance, sustained completion.	11/27/2022

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	WY9060	A. BUILDING _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

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F 880	Continued From page 11	F 880	Monitoring and Tracking and Responsible Person(s):	

and donned gloves. After assisting the resident to lie down, the CNAs removed the resident's pants and incontinence brief and performed perineal care. After wiping the resident's perineal area CNA #2 obtained more wipes and a clean brief, touching the door handle of the bedside cabinet, without removing his gloves. CNA #3 assisted the resident to roll to his/her left side and CNA #2 wiped the resident's rectal area, removing stool from the resident. The CNA cleaned the resident with his right hand and then used the same hand to hold the container of wipes while reaching into the container with his left hand. While continuing to perform incontinence care, CNA #2's glove became visibly soiled and he stopped care, removed his gloves, and performed hand hygiene. The CNA donned clean gloves and continued to perform incontinence care to remove the remainder of the stool. Continued observation showed CNA #2 placed the clean brief under the resident and the CNAs assisted the resident to return to his/her back. CNA #2 performed additional perineal care without performing hand hygiene or changing his gloves. At that time CNA #3 obtained wipes and demonstrated how perineal care was to be performed. When the perineal care was complete, both staff members secured the resident's brief and did not perform hand hygiene or remove their gloves prior to pulling up the resident's pants, covering the resident with a blanket, or raising the resident's bed rails.

2. Interview with the DON on 10/13/22 at 9:54 AM revealed she expected staff to perform hand hygiene upon entering a resident room and before exiting the room. In addition, staff should prepare supplies prior to the start of care and should don clean gloves after coming in contact

All monitoring will be reported to the QAPI Committee monthly as part of QAPI activities. Monitoring will continue until the facility completes 3 consecutive monthly rounds, demonstrating sustained completion.

The infection preventionist (IP) and director of nursing (DON) are responsible for compliance.

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F 880	Continued From page 12	F 880		

with soiled items, prior to touching clean items. Further interview revealed if she observed staff perform incontinence care and touch clean items prior to removing their soiled gloves, she would assign additional education for the staff member to complete.

3. Review of the policy titled "Handwashing/Hand Hygiene" dated 4/1/22 showed "...6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. Difficile. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...b. before and after direct contact with residents;...h. before moving from a contaminated body site to a clean body site during resident care;...i. After contact with a resident intact skin; j. After contact with blood or body fluids;...m. After removing gloves;..."