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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/11/24 through 3/14/24. Also reviewed in the course of the survey were complaint intakes WY00003754, WY00003823, and WY00003824. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status cm: centimeters CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set MAR: Medication Administration Record mg: milligrams PRN: acronym for Latin term "pro re nata" which means "as needed" RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		4/19/24

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

Electronically Signed | 04/06/2024

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, resident representative interview, and resident rights review, the facility failed to ensure 1 of 25 sample residents (#54) was treated with dignity and care in a manner that promoted quality of life. The finding were: 1. Review of the quarterly MDS assessment dated 3/14/24 showed resident #54 had severely impaired cognition. The diagnoses included	F 550	F550 Corrective Action Resident #54 has expired. Identification of Others Initial audit completed by DNS/Designee of resident right/grievances related to dignity issues over the last ninety days to assess for other concerns related to this deficiency. Corrective actions provided if needed. Systemic Changes	

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F 550	Continued From page 2 medically complex conditions, wound infection, other fracture, non-Alzheimer's dementia, and depression. The resident required extensive assistance with dressing, toileting, and personal hygiene. The following concerns were identified: a. Review of the 11/21/23 at 9:59 PM progress note showed "Communication with Family/NOK/POA, resident's daughter, expressed her dissatisfaction with resident's haircut. "I told them to let me know when [s/he] needs a haircut. I have someone hired to come in and cut [his/her] hair. I don't want [his/her] head buzzed like this." b. Review of the 11/22/23 at 3:16 PM progress note showed "Communication with Family/NOK/POA, spoke with daughter regarding the hair cut. Explained to her that the staff, who are relatively new in the unit, were not aware that [daughter name] had a hairdresser who comes in to do resident's hair and for her to be notified if resident needs a haircut. DNS explained to daughter that staff was just trying to make [him/her] presentable for his/her family for Thanksgiving. She expressed that her brother is very upset over the situation. A grievance has been filed on the family's behalf." c. Interview with the social services director on 3/14/24 at 8:40 AM revealed the family did not ask the facility to cut the resident hair, and the facility did not notify the family s/he needed a hair cut. He stated the family had arrangements with somebody to cut the resident's hair when needed. The grievance was communicated with the daughter in person of the outcome on 11/22/23. Staff was educated afterwards. He revealed the facility does try and spruce the residents up, to help keep them clean. d. Review of the "Establish the Baseline Plan of Care" last revised on 12/13/23 showed "Contact [daughter name] for any change in	F 550	Education provided by the ED to current staff related to resident rights/grievance policy. Ongoing audits to be completed by the ED/Designee two times per week for three months to assess resident rights and grievances related to dignity issues for timely and appropriate follow up. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	

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F 550	Continued From page 3 care/treatment or other atypical intervention." "Grooming:Personal Hygiene assistance needed: Dependent." 2. Interview with the resident's daughter on 3/14/24 at 10:10 AM revealed the facility had cut the resident's hair before and was told not to. She stated that she hires a person to come in and cut his/her hair when needed. Further, she stated "I did not authorize his/her head to be shaved. Then they go and cut it before Thanksgiving. [S/he] did not look good." 3. Review of the "Notice of Resident Rights Under Federal Law" given by the facility on 3/14/24 at 1:22 PM showed "...4. The resident has the right to be informed, in advance, of the care furnished and the type of caregiver or professional that furnishes care."	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		4/19/24

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§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and

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F 585	Continued From page 5 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, medical record review, facility	F 585	F585 Corrective Action A grievance for discharged resident #104	

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grievance log review, and policy and procedure review, the facility failed to ensure the grievance procedure was followed for 1 of 6 sample residents (#104) reviewed for reported grievances. The findings were:

1. Review of the "Discharge Transition Plan" dated 2/9/24 and timed 8:10 AM showed resident #104 had a planned discharge scheduled for 2/10/24. Further review showed the resident's representative and social services director signed the plan on 2/10/24. Review of the "Recapitulation of Resident Stay" dated 2/12/24 showed the resident discharged from the facility on 2/10/24. The following concerns were identified:

a. Interview with the resident's representative on 3/14/24 at 8:33 AM confirmed the resident discharged from the facility on 2/10/24 and revealed she reported concerns of missing items to the social services director at the time of discharge. The resident's representative revealed the missing items reported included a pair of swim shoes, 2 white shirts, a pair of pajamas, and a glasses case. The representative revealed 1 shirt was found and returned; however, the other items were still missing and the facility had not contacted her for resolution.

b. Review of the grievance log for February 2024 and March 2024 showed no evidence of a grievance for the resident related to the missing items.

c. Interview with the social services director on 3/14/24 at 9:17 AM revealed after the resident discharged from the facility, he was notified by the resident's representative there were some items missing. The missing items included swim shoes, a glasses case, and some white shirts. He confirmed 1 white shirt was found and returned to the resident's representative on 3/13/24. He was filed. SS contacted the resident's representative about the missing items. The resident's representative stated that she did not want the items replaced, but if they are found to notify her. The pair of swim shoes was found and representative was notified, but has yet to come and pick them up.

Identification of Others
Initial audit completed by ED/Designee of grievances for discharged residents over the last ninety days to ensure no others were affected by the deficient practice. Residents affected have been corrected.

Systemic Changes
Education provided by the ED to current staff related to the grievance policy. Ongoing audits completed by the ED/Designee two times per week for three months to assess grievances for timely and appropriate follow up.

Monitoring for Compliance
Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.

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F 585	Continued From page 7 revealed a grievance form was not completed because the facility continued to look for missing items and the resident's representative was aware. 2. Review of the policy titled "Grievance Procedure" Last revised November 2016 showed "...7. When an immediate resolution is not possible, the grievance is routed to the Grievance Official and/or Social Services/designee within 24 hours. The individual receiving the grievance fills out a Grievance Form...9. Social Services or designee routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within two business days, and returns the Grievance for to Social Services or designee. 10. The Person with the grievance has a right to a written decision regarding his/her grievance. 11. Social Services/designee logs Grievance Forms on the Grievance Log..."	F 585		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to promptly identify and intervene for an acute	F 684	F684 Corrective Action Resident #29 is followed by their primary physician and licensed center staff and is	4/19/24

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F 684	Continued From page 8 change in condition for 2 of 4 sample residents (#29, #31) who experienced a change in condition. This failure resulted in actual harm to residents #29 and #31 who experienced changes in condition including limited movement and pain following a fall and did not receive a thorough assessment in a timely manner to assess for injuries based on their signs and symptoms. The findings were: 1. Review of the 2/13/24 significant change MDS assessment showed resident #29 had diagnoses including polyosteoarthritis, non-Alzheimer's dementia, and other chronic pain. The resident received scheduled pain medication and had no pain in the last 5 days. Review of a progress note dated 3/10/24 showed the resident was found on the floor beside the bed. "A new 2 cm curved lacerated noted on left forearm. Denies hitting head, admits to shoulder pain. Range of motion limited and at baseline. Chronic shoulder deformity related to previous surgery noted and at baseline. No swelling or discoloration noted...Shoulder pain treated with PRN ordered pain medications...on call provider notified. New orders received to schedule resident appointment with primary clinic for further evaluation related to recent frequent falls and further evaluation to rule out additional injuries." A progress note dated 3/11/24 and timed 5:28 AM showed "...Will remind day shift nurse that [his/her] MD is requesting to see [him/her] at the clinic." The following concerns were identified: a. Observation on 3/11/24 at 3:43 PM showed RN #2 asked the resident about pain and the resident said his/her pain was an "8." b. Observation on 3/11/24 at 5:08 PM showed the resident complained of shoulder pain to CNA #1. The resident was cradling his/her left arm with	F 684	provided timely identification as well as appropriate interventions related to acute changes in condition. Resident #31 is followed by their primary physician and center licensed staff and is provided timely identification as well as timely and appropriate interventions related to acute changes in condition. Identification of Others Initial audit completed by DNS/Designee to assess for other resident concerns related to the timely identification of acute changes of condition as well as timely interventions of acute changes of condition. Corrective actions provided if needed. Systemic Changes Education provided by DNS/Designee related to timely identification of acute changes of condition with timely and appropriate interventions provided. Ongoing audits will be completed by DNS/Designee five days per week, for at least three months, during the morning clinical meeting using the 24-hour and/or 72-hour report to identify acute changes of condition and provide timely interventions with physician consult. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	

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the other arm and stated s/he couldn't raise their arm up. When the CNA asked the resident how s/he would rate the pain, the resident replied "10." The resident stated the nurse put some cream on his/her shoulder earlier, but "it didn't help." When the surveyor asked what happened, the resident replied s/he fell the day before and had not seen a doctor.

c. Observation on 3/11/24 at 5:33 PM showed the resident wasn't eating much of his/her dinner and kept looking at his/her left arm and telling the surveyor s/he couldn't raise their arm.

d. On 3/11/24 at 5:40 PM RN #2 came to the SCU and CNA #1 told her the resident was complaining of pain at a "10" and couldn't raise his/her arm. The nurse evaluated the resident's arm and the resident winced when the nurse moved his/her left arm. There was bruising visible to the resident's outer bicep area. At 5:46 PM the RN cleaned a bleeding scab on the resident's arm and told the resident she would call the doctor to see if he wanted treatment for the scab.

e. On 3/11/24 at 5:48 PM RN #2 took the resident to his/her room. The resident told her the pain level was a "9." The resident told the nurse s/he fell the day before. At 5:54 PM the RN applied a cream to the resident's left shoulder and arm. She stated she applied cream to the resident earlier. She also told the resident s/he last had Tylenol at noon and she would check on any other orders. The RN told the surveyor she was not notified in report that the resident fell the day before.

f. On 3/11/24 at 6:03 PM the RN clarified to the surveyor that the report sheet did say the resident fell the day before, but it stated there were no injuries.

g. Review of the nursing note dated 3/11/24 and timed 7:52 PM showed "...Resident has been

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complaining of left shoulder to the hand pain. [S/he] has been favoring left extremity throughout the day. Topical Diclofenac Sodium Gel was applied to the shoulder and po Tylenol was given. A noted abrasion to left forearm was cleaned and left open to air. PCP appt needs to be made for resident..."

h. Review of progress notes from 3/11/24 and the morning of 3/12/24 showed no evidence nursing had made an appointment for the resident with his/her doctor, despite the nursing notes dated 3/10/24 and 3/11/24 which indicated an appointment was supposed to be made.

i. Review of the MAR for 3/11/24 showed the resident was administered the routine medications of Diclofenac Sodium gel 1%, apply 2 grams to upper extremities, at 7 AM, 3 PM and 11 PM and Tylenol ES 500 mg, give 2 tablets, at 8 AM, noon and 4 PM. Further review of the MAR showed the resident was ordered Oxycodone HCL 5 mg every 8 hours as needed for severe pain. However, the resident was not administered any Oxycodone on 3/11/24.

j. On 3/12/24 at 11:23 AM physician #1 entered the SCU and the surveyor asked if he was there to see resident #29. He stated no, he was not the resident's physician, but asked what was going on. The surveyor told the physician about the resident's complaints of shoulder pain following a fall and the physician stated he would examine the resident. The physician went in the resident's room and exited a few moments later and told the surveyor they would be getting xrays for the resident.

k. During an interview on 3/12/24 at 4:34 PM the DON stated physician #1 told them to get in touch with the resident's physician, so she stated she called the resident's physician at 12:30 PM. She stated the physician had not gotten back to

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her yet. She stated the resident was complaining of pain, which was normal, but was worse since the fall.

l. Observation on 3/12/24 at 4:56 PM showed the staff development coordinator (SDC) took the resident to his/her room to assess the resident. When the surveyor asked the resident if s/he still had pain in that arm the resident indicated yes, and stated the upper and lower arm hurt. When the SDC was asked if the resident normally complained of pain, she stated not usually in the upper extremities.

m. Review of a nursing note dated 3/12/24 and timed 5:46 PM showed "...Resident had complaint of increased pain to left shoulder...Resident was unable to lift up left arm at this time. Faded bruise to left upper inner arm observed...bruise appears old...Due to increased pain and decreased function of arm, resident is being sent to receive imaging per MD order. "

n. Review of a progress noted dated 3/12/24 and timed 5:46 PM showed "Received order from MD to send resident out to ER for X-ray to left shoulder."

o. Review of a nursing note dated 3/12/24 and timed 9:30 PM showed "...Resident recently returned to the facility from [hospital] ER tonight. Resident received x-rays to r/o [rule out] injury of left upper extremity r/t [related to] recent fall per complaints of pain. Per verbal report, resident has old, resolved injuries to left upper extremity that have been aggravated by recent fall. No acute injury. Resident was sent home with sling in place to left upper extremity. Rest of left upper extremity and follow up with Orthopedics if condition does not improve. Resident was medicated for pain at [hospital] ER before returning to the facility..."

p. A progress note dated 3/13/24 read "IDT

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aware of resident's c/o left shoulder/arm pain. MD was contacted. Resident sent to ER for X-Ray to left shoulder. Resident returned from ER with diagnoses for contusion of left shoulder and post-traumatic osteoarthritis of left shoulder...Resident sent back to facility with sling in place. Therapy referral initiated."

q. On 3/13/24 at 4:25 PM RN #2 stated on 3/11/24 the resident was exhibiting signs of pain and holding his/her arm. She stated she did not give the resident the ordered PRN Oxycodone because she was told to only give it to him/her at night because the resident got up and walked by himself/herself. She stated she was told that day the resident needed to see his/her PCP (primary care physician), but she was told to pass it along to the "regular" nurse since she was just filling in. She stated she told the night nurse, who was supposed to pass it along to the "regular" day nurse who would be working the following day and would know how to contact the physician.

r. During an interview on 3/14/24 at 8:45 AM the resident stated his/her pain was a "9," but stated the sling on his/her arm made his/her arm more comfortable.

s. Review of a nursing note dated 3/13/24 at 9:59 PM showed "...Sling to left upper extremity remains in place...Slight swelling noted to left hand..."

2. Review of the 1/22/24 quarterly MDS assessment showed resident #31 had a BIMS score of 0, indicating severe cognitive impairment, had a diagnosis of non-Alzheimer's dementia, had no indicators of pain, and had one fall with no injury since the previous assessment. Observation on 3/11/24 at 4:51 PM and on 3/12/24 at 9:16 AM revealed the resident was in bed. Review of an IDT note dated 3/4/24 showed

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on 3/3/24 the resident fell while standing in front of the recliners. The note showed the resident was exhibiting increased back pain. The following concerns were identified:

a. Review of a nursing note dated 3/5/24 and timed 2:15 PM showed "...Recent fall approximately 2 days ago. Declined offers to have breakfast this AM and remained in bed until lunch...Guarding of lower back also noted with repositioning...Resident agreed to get up for lunch. Resident noted to be leaning back while sitting in chair, grimacing and lower back guarding noted when resident leans forward..."

b. Review of a nursing note dated 3/9/24 and timed 1:37 PM showed "...Resident remained in bed today...Guarding of lower back noted when resident is repositioned, otherwise no indications of pain while at rest.."

c. Review of a nursing note dated 3/10/24 and timed 6:58 PM showed "Remained in bed for shift. Facial grimacing and guarding of lower back noted with repositioning, however no other indications of pain noted while at rest.

d. Review of the MAR for March 2024 showed the resident received PRN Tylenol 650 mg on 3/3 for back pain at a "6"; on 3/6 for pain at a "4"; on 3/7 for pain at a "4"; on 3/10 for back pain at a "2"; and on 3/12 for pain at a "3."

e. Review of a progress note dated 3/12/24 and timed 8:21 AM showed "Resident sent out for X-Rays to [his/her] lower back following [his/her] fall the other day. Since the fall, resident has been displaying non-verbal indicators of pain. X-ray was done. Age-indeterminate compression fractures found at L2 and L3 with degenerative arthroplasty to L5-S1...Resident has been remaining in bed for the majority of [his/her] days..."

f. During an interview on 3/14/24 at 10:55 AM

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F 684	Continued From page 14 the DON was asked why the resident was not sent for x-rays sooner. The DON stated that she was not notified by nursing what was going on with the resident. She stated once she found out, she sent the resident for x-rays.	F 684		
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 by: Based on observation, medical record review, and staff and resident interviews, the facility failed to provide necessary treatment to promote healing for 2 of 5 sample residents (#50, #105) with pressure ulcers. The findings were: 1. Review of the 3/3/24 admission MDS assessment showed resident #50 had diagnoses including renal insufficiency and was at risk for pressure ulcers, but did not have any. Review of a progress note dated 3/5/24 showed therapy called the nurse to assess the resident's heel when blood was observed on the resident's left sock. A 5 x 4.5 x 0.1 cm serosanguinous filled	F 686	F686 Corrective Action Resident #105 has since been discharged from the facility. Resident #50 has current orders being followed by clinical staff including treatment change frequency. Identification of Others Initial audits completed by DNS/Designee to assess others who may have been affected by deficient practices. Concerns identified corrected as needed. Systemic Changes Education provided to licensed nurses by DNS/Designee related to providing treatment as ordered including treatment	4/19/24

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F 686	Continued From page 15 blister was observed to the left heel. Review of a progress note dated 3/12/24 showed the pressure ulcer to the left heel was 4.5 x 4.5 x 0.1 cm and new epitheliazation was observed around the wound edges. Observation on 3/12/24 at 10:40 AM showed RN #1 provided wound care to the left heel. Review of physician orders showed on 3/5/24 the physician ordered for the wound to be cleaned with wound cleanser, covered with skin prep, a non adherent foam applied and then covered with mepilex. The order was for the dressing to be changed every day and as needed if the dressing became soiled or fell off. The following concerns were identified: a. During an interview on 3/12/24 at 8:38 AM the resident stated s/he had a wound on the left heel. When asked if staff were providing care for it, the resident responded that they hadn't provided treatment the last couple of days. b. Review of the medical record, including the treatment administration record (TAR), progress notes and nursing assessments, showed no evidence the facility provided wound treatment on 3/10/24 or 3/11/24. c. On 3/14/24 at 10:55 AM the DON stated wound documentation would be in the medical record and did not provide any additional documentation. 2. Review of the 3/5/24 admission MDS assessment showed resident #105 had diagnoses including weakness and cellulitis of the lower extremity and had one stage 2 pressure ulcer. Review of the 3/6/24 weekly skin evaluation showed the resident had a stage 2 pressure ulcer to the right heel which measured 6 x 6 x 0.1 cm. Observation on 03/13/24 at 11:40 AM showed the SDC performed wound care to the right heel. Review of physician orders showed on 3/6/24 the	F 686	frequency with appropriate documentation. Ongoing audits will be completed by DNS/Designee weekly times three months to assess for timely treatment completion with appropriate documentation. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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F 686	Continued From page 16 physician ordered the right heel wound to be cleansed with wound cleanser, calcium alginate applied to wound bed, and a non adherent foam placed and wrapped with gauze wrap and an ace bandage from the toes to the knees. The dressing was ordered to be changed every day and as needed if the dressing was soiled or came off. The following concerns were identified: a. Review of the medical record, including the TAR, progress notes and nursing assessments, showed no evidence the facility provided wound treatment on 3/10/24 or 3/11/24. b. On 3/14/24 at 10:55 AM the DON stated wound documentation would be in the medical record and did not provide any additional documentation.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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	F 692		4/19/24

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F 692	Continued From page 17 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure therapeutic diets were provided in accordance with physician's orders during 1 of 3 meal observations. Random observations showed thickened liquids were not appropriately provided for resident #28 and resident #43. The following concerns were identified: 1. Observation on 3/11/24 at 5:03 PM showed CNA #2 obtained a small container of white powder which was not covered, labeled, or dated, she referred to as "thickener," from on top of the book shelf in the dining room. The CNA dumped the contents of the container into a plastic cup, then poured hot cocoa into the cup. The CNA stirred the contents briefly and provided to the cup of fluid to resident #28. The resident took a drink of the fluid and coughed several times after drinking. Continued observation throughout the meal showed the resident did not drink any more of the hot cocoa during the meal. 2. Review of the medical record for resident #28 showed s/he had an active physician's order for "...puree texture, mildly thick liquid consistency..." 3. Observation on 3/11/24 at 5:11 PM showed CNA #3 opened a small container from the fluid cart, which was not labeled or dated, of white powder she called "thickener." The CNA placed 1 plastic spoon full in a cup then added liquid. The CNA stirred the liquid and checked consistency by lifting the spoon and allowing the fluid to run off. The CNA obtained another plastic spoon and	F 692	F692 Corrective Action Resident's #28 and #43 are currently receiving thickened liquids per facility protocol and physician diet orders. Identification of Others Initial audits completed by ED/Designee to assess others who may have been affected by deficient practices. Residents affected are corrected as needed. Systemic Changes Education provided to current staff by ED/Designee regarding dietary staff is responsible for thickening liquids and having the appropriate thickened liquids ready to provide to residents at each meal and or snacks. Ongoing audits will be completed by ED/Designee twice weekly times three months to assess for compliance. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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added an additional amount of powder to the tip of the spoon and put the powder in the glass. She stirred the fluid and tested the consistency by lifting the spoon and allowing the fluid to run off. The CNA an additional amount of powder to the tip of the 2nd spoon and put the powder in the glass. She again stirred the fluid and tested the consistency by lifting the spoon and allowing the fluid to run off. The liquid was still splashing when it was dripped back into the cup of fluid, and it was provided to resident #43. Interview with CNA at that time revealed using the powdered thickener was new to her and she usually used the liquid which had a pump and instructions to determine the needed amount for different consistencies. She revealed with the powder she normally "just dumps a little out at a time."

4. Review of the physician's orders for resident #43 showed no active orders for thickened liquid consistency.

5. Interview with CNA #2 on 3/11/24 at 5:20 PM revealed the kitchen usually measured out the amount of powdered thickener to use. She stated normally the facility used liquid thickener and the container indicated how many pumps to use for different consistencies. She stated with the containers of thickener on the cart, it depends how many glasses they can thicken because they have to measure them out with the scoops. Observation at that time showed there was no scoop present in the small containers or on the fluid cart.

6. Interview with the facility dietitian on 3/14/24 at 10:37 AM revealed she would direct questions about CNAs thickening liquids to the DON and the administrator. Further interview revealed the

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F 692	Continued From page 19 dietary department had pre-thickened liquids and staff should follow directions for using thickener to thicken fluids to the appropriate thickness. 7. Interview with the DON on 3/14/24 at 10:54 AM revealed the floor staff should not be thickening liquids and the thickening of liquids should be performed by dietary staff only.	F 692		
F 697 SS=G	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, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interview, and review of policies and procedures, the facility failed to adequately treat pain for 1 of 6 sample residents (#29) reviewed for pain management. This failure resulted in actual harm to resident #2 who experienced a change in condition including limited movement and pain following a fall and was not treated for severe pain. The findings were: 1. Review of the 2/13/24 significant change MDS assessment showed resident #29 had diagnoses including polyosteoarthritis, non-Alzheimer's dementia, and other chronic pain. The resident received scheduled pain medication and had no pain in the last 5 days. Review of a provider progress note dated 2/7/24 showed the resident had chronic pain of the right knee and lift hip.	F 697	F697 Corrective Action Resident #29 is adequately treated for pain management via routine and as needed oral pain medications as well as topical analgesics. Resident #29's physician is aware and involved with this resident's pain management program. Identification of Others Initial audit completed by DNS/Designee to assess for other residents who may have pain control concerns with timely Physician contact made if required. Systemic Changes Education provided by DNS/Designee to current staff regarding pain management including timely and appropriate identification, Physician notification, and treatment of pain. Ongoing audits will be completed by DNS/Designee five days per	4/19/24

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F 697	Continued From page 20 Review of the care plan for pain initiated 4/13/24 showed "Administer analgesia as per orders..." and "Evaluate the effectiveness of pain interventions Q shift. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition." Review of physician orders and the MAR for March 2024 showed the resident was ordered the following routine medications for pain: Diclofenac Sodium 1% gel to the upper and lower extremities (4 grams to lower extremities, 2 grams to upper extremities) every 8 hours for pain (at 7 AM, 3 PM and 11 PM) and Tylenol ES 500 mg, give two tablets, three times per day (6 AM, noon, 4 PM). In addition, the resident was ordered Oxycodone HCL 5 mg every 8 hours PRN (as needed) for severe pain. Further review of physician orders and the MAR showed staff were instructed to monitor pain every shift and indicate pain level and location if applicable. The following concerns were identified: a. Review of a progress note dated 3/10/24 showed the resident was found on the floor beside the bed. "A new 2 cm curved lacerated noted on left forearm. Denies hitting head, admits to shoulder pain. Range of motion limited and at baseline. Chronic shoulder deformity related to previous surgery noted and at baseline. No swelling or discoloration noted...Shoulder pain treated with PRN ordered pain medications...on call provider notified. New orders received to schedule resident appointment with primary clinic for further evaluation related to recent frequent falls and further evaluation to rule out additional injuries." b. Observation on 3/11/24 at 3:43 PM showed RN #2 asked the resident about pain and the resident said his/her pain was an "8."	F 697	week, for at least three months, during the morning clinical meeting using the 24-hour and/or the 72-hour report to identify uncontrolled pain concerns with identified concerns being addressed timely with physician consult. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	

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c. Observation on 3/11/24 at 5:08 PM showed the resident complained of shoulder pain to CNA #1. The resident was cradling his/her left arm with the other arm and stated s/he couldn't raise their arm up. When the CNA asked the resident how s/he would rate the pain, the resident replied "10." The resident stated the nurse put some cream on his/her shoulder earlier, but "it didn't help." When the surveyor asked what happened, the resident replied s/he fell the day before and had not seen a doctor.

d. Observation on 3/11/24 at 5:33 PM showed the resident wasn't eating much of his/her dinner and kept looking at his/her left arm and telling the surveyor s/he couldn't raise their arm.

e. On 3/11/24 at 5:40 PM RN #2 came to the SCU and CNA #1 told her the resident was complaining of pain at a "10" and couldn't raise his/her arm. The nurse evaluated the resident's arm and the resident winced when the nurse moved his/her left arm.

f. On 3/11/24 at 5:48 PM RN #2 took the resident to his/her room. The resident told her the pain level was a "9." The resident told the nurse s/he fell the day before. At 5:54 PM the RN applied a cream to the resident's left shoulder and arm. She stated she applied cream to the resident earlier. She also told the resident s/he last had Tylenol at noon and she would check on any other orders.

g. Review of the nursing note dated 3/11/24 and timed 7:52 PM showed "...Resident has been complaining of left shoulder to the hand pain. [S/he] has been favoring left extremity throughout the day. Topical Diclofenac Sodium Gel was applied to the shoulder and po Tylenol was given. A noted abrasion to left forearm was cleaned and left open to air. PCP appt needs to be made for resident..."

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h. Review of the MAR for 3/11/24 showed the resident was administered the routine medications of Diclofenac Sodium gel 1%, apply 2 grams to upper extremities, at 9:30 AM, 3:40 PM and 11 PM and Tylenol ES 500 mg, give 2 tablets, at 8 AM, noon and 4 PM. However, the resident was not administered any PRN Oxycodone on 3/11/24, despite the resident indicating s/he had severe pain.

i. Review of the MAR for March 2024 showed the day shift nurse did not document the resident's pain (pain level and location) on 3/11/24. Review of the vital signs in the electronic medical record showed pain level was not documented on 3/11/24.

j. Observation on 3/12/24 at 4:56 PM showed the SDC took the resident to his/her room to assess the resident. When the surveyor asked the resident if s/he still had pain in that arm the resident indicated yes, and stated the upper and lower arm hurt. When the SDC was asked if the resident normally complained of pain, she stated not usually in the upper extremities.

k. Review of a nursing note dated 3/12/24 and timed 5:46 PM showed "...Resident had complaint of increased pain to left shoulder...Resident was unable to lift up left arm at this time. Faded bruise to left upper inner arm observed...bruise appears old...Due to increased pain and decreased function of arm, resident is being sent to receive imaging per MD order. "

l. Review of a nursing note dated 3/12/24 and timed 9:30 PM showed "...Resident recently returned to the facility from [hospital] ER tonight. Resident received x-rays to r/o [rule out] injury of left upper extremity r/t [related to] recent fall per complaints of pain. Per verbal report, resident has old, resolved injuries to left upper extremity that have been aggravated by recent fall. No acute

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WIND RIVER REHABILITATION 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 697	Continued From page 23	F 697		

injury. Resident was sent home with sling in place to left upper extremity. Rest of left upper extremity and follow up with Orthopedics if condition does not improve. Resident was medicated for pain at [hospital] ER before returning to the facility..."

m. On 3/13/24 at 4:25 PM RN #2 stated on 3/11/24 the resident was exhibiting signs of pain and holding his/her arm. She stated she did not give the resident the ordered PRN Oxycodone because she was told to only give it to him/her at night because the resident got up and walked by himself/herself.

n. Review of a progress note dated 3/13/24 showed "...Resident was very agitated and restless at the beginning of this shift. Resident replied "yes" when asked if [s/he] wanted a pain pill. Resident was medicated for pain and agitation has improved."

o. Review of the MAR for 3/12/24 and 3/13/24 showed the resident did receive PRN Oxycodone on those days.

p. During an interview on 3/14/24 at 8:45 AM the resident stated his/her pain was a "9," but stated the sling on his/her arm made his/her arm more comfortable.

2. Review of the facility's policy "Pain Management," updated August 2023, showed "...2. Resident's pain level is evaluated every shift by the LN [licensed nurse]. Noted pain is evaulated and treated accordingly by the LN...a. Pain level is monitored and documented on the MAR using the Wong-Baker Pain Scale...3. When pain is not adequately controlled by current regimen, or if there is newly identified pain, the LN contacts the physician for consideration of new or modified treatment orders."

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F 803	Continued From page 24	F 803		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, and staff interview, the facility failed to ensure the menu was followed for 1 of 1 meals observed for meal preparation and tray line service. The findings were: 1. Review of the menu for the 3/13/24 lunch meal showed it included cranberry glazed pork loin,	F 803	F803 Corrective Actions Residents #40, #39, #28, #34, #1, #24, and #13 are currently receiving correct CCHO diets as per ordered by the physician. Identification of Others Initial audit completed by ED/Designee on diet orders to assess residents who may	4/19/24

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F 803	Continued From page 25 baked potato, beets, and a roll for the regular diet. However, the CCHO (consistent carbohydrate diet for diabetes) menu consisted of a baked pork loin, 1/2 baked potato, beets, and no roll. The following concerns were identified during tray line service on 3/13/24 from 12:03 PM through 12:59 PM: a. Resident #40 had a CCHO diet and was served cranberry sauce over the pork, a whole potato, beets, and a roll. b. Resident #39 had a CCHO diet and was served cranberry sauce over the pork, half a potato, beets, and a roll. c. Resident #28 had a CCHO diet and puree texture and was served pureed pork with the cranberry sauce, pureed beets, mashed potatoes, and pureed bread. d. Resident #34 had a CCHO diet and soft and bite sized texture and was served ground pork with cranberry sauce, mashed potatoes, ground beets, and a roll. e. Resident #1 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets, and a roll. f. Resident #24 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets and a roll. g. Resident #13 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets and a roll. 2. During an interview on 3/13/24 at 4:32 PM the certified dietary manager (CDM) confirmed residents with a CCHO diet order should not have received the cranberry sauce over the pork, should have received half a potato, and should not have received a roll.	F 803	be affected by deficient practice. Residents affected have been corrected as needed. Systemic Changes Education provided by ED/Designee to current staff related to diet order practices. Ongoing audits will be completed by ED/Designee twice weekly for three months to assess for correct diet orders. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		4/19/24

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F 812	Continued From page 26 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the 2022 Food Code, the facility failed to store and prepare food in accordance with professional standards related to expired food, hair restraints, and hand hygiene/gloving during 3 of 3 observations in the kitchen and 1 of 1 observation of tray line service. The findings were: 1. The following concerns were identified related to hair restraints: a. Observation on 3/11/24 at 3:15 PM in the kitchen revealed the certified dietary manager (CDM) was wearing a hair restraint, but was not wearing a beard restraint to cover his beard. b. Observation on 3/13/24 at 12:21 PM revealed the CDM was assisting staff with tray	F 812	F812 Corrective Action Food prep workers are currently using hair coverings and beard restraints as appropriate. Food prep workers are following hand hygiene/gloving protocol. Any expired food has been removed from the kitchen/storage areas. Identification of Others Initial audit completed by ED/Designee related to hair coverings, beard restraints, hand hygiene/gloving protocol, and expired foods. Systemic Changes Education provided to current kitchen staff related to food safety as related to hair coverings, beard restraints, hand	

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F 812	Continued From page 27 line service (putting sour cream on the trays in the carts) and was not wearing a beard restraint to cover his beard. c. During an interview on 3/13/24 at 4:32 PM the CDM stated he had heard about beard restraints but had never worn one. Review of the 2022 Food Code, US Food and Drug Administration, showed "...2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES." 2. The following concerns were identified related to hand hygiene/gloving: a. Observation during tray line service on 3/13/24 from 12 PM to 12:59 PM showed cook #1 washed her hands and put on gloves at the beginning of the service. During the service, the cook was observed to touch the microwave buttons and handle with her gloved hands, and then touched the bread of grilled cheese sandwiches, tortillas, and cooked baked potatoes with the same gloved hands. This happened on at least five occasions.	F 812	hygiene/gloving protocol, and expired foods. Ongoing audits to be completed by ED/Designee twice weekly times at least three months to assess for compliance. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	

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F 812	Continued From page 28 b. During an interview on 3/13/24 at 4:32 PM the CDM stated staff had been educated on hand hygiene and glove use. He stated staff should perform hand hygiene and change gloves between tasks and confirmed the cook should have performed hand hygiene after touching the microwave surface and before handling food. Review of the 2022 Food Code, US Food and Drug Administration, showed "...2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); P (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands." 3. The following concerns were identified regarding expired food:	F 812		

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F 812	Continued From page 29 a. Observation of the dry storage room on 3/11/24 at 3:15 PM showed 2 packages of flour tortillas that expired January 10, 2024. b. Observation on 3/13/24 at 10:52 AM of the dry storage showed one of the two packages of expired flour tortillas remained on the shelf. c. On 3/13/24 at 10:55 AM the CDM stated everything in dry storage was useable, and stated he did not know the tortillas were expired. d. On 3/13/24 at 11:20 AM in the kitchen the CDM showed the surveyor a box which contained flour tortillas. He stated that was the box the flour tortillas from the dry storage came from and they received the box on 2/14/24. He showed the surveyor that all of the tortillas in the box expired in January 2024.	F 812		
F 880 SS=D	Infection Prevention & Control 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	F 880		4/19/24

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F 880	Continued From page 30 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 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	F 880		

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F 880	Continued From page 31 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 professional reference review, the facility failed to ensure infection prevention techniques were followed for 1 of 5 sample residents (#50) during wound care. The findings were: 1. Observation of wound care for resident #50 on 3/12/24 at 10:40 AM showed RN #1 cleaned a surgical wound on the resident's abdomen, below the umbilical, with wound cleanser and gauze. Without removing her gloves or performing hand hygiene, the RN opened a package of xeroform impregnated gauze and placed it over the site, opened a second package of xeroform impregnated gauze and placed it over the site, and opened an abdominal (ABD) dressing and applied over the xeroform. At that time, the RN removed her gloves, used some scissors from her pocket, cut a strip of medifix tape, and applied it to the top of the ABD dressing. The RN tucked the lower bottom portion of the ABD dressing into the resident's incontinence brief. The RN applied clean gloves and got on her hands and knees in a position to perform a dressing change to the resident's left heel, touching the floor with the clean gloves in the process. Without removing her gloves, she removed the resident's left heel dressing, and cleaned the wound with wound cleanser and gauze. The RN obtained the scissors from the bed side table, opened a dermarite foam	F 880	F880 Corrective Action Resident #50 is receiving wound care per Physician orders while following infection control protocol. Identification of Others Initial wound care observation audits completed by DNS/Designee. Education related to infection control protocol provided to those observed as needed. Systemic Changes Education provided to current nursing staff related to infection control protocol as related to wound care. Ongoing wound care observation audits will be completed by DNS/Designee twice weekly times at least three months to assess for compliance. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.	

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F 880	Continued From page 32 dressing, cut the dressing to size, and applied the foam to the resident's heel wound. The RN covered the dermarite foam dressing with a comfortfoam border dressing, and secured it to the resident's heel. At that time, the RN got off the floor and placed the contaminated scissors in her pants pocket with pens and other items. The RN entered the bathroom, removed her gloves, and performed hand hygiene. 2. Interview with the wound nurse/infection preventionist on 3/14/24 at 9:30 AM revealed she expected staff to clean items before leaving a resident's room because items in the room are considered contaminated. She confirmed she would consider the scissors contaminated, when they were used during a wound dressing change, if they were not cleaned after use. In addition, she expected gloves to be changed after cleaning a wound, prior to touching a clean dressing, to prevent contamination. 3. Review of Perry/Potter seventh edition "Nursing Interventions & Clinical Skills" copyright 2020 showed "Performing a Wound Assessment ...5. Perform hand hygiene. b. expose only the area of the wound... 8. Apply clean gloves and remove soiled dressings... 10. Perform hand hygiene and apply clean gloves. 11. Inspect wound... 14. Apply dressings per order. Place time, date, and initials on new dressing..."	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 921		4/19/24

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F 921	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents, staff, and public. The census was 56. The findings were: 1. Observation on 3/12/24 at 4:40 PM showed broken floor tiles outside the soiled utility room near room #35. The area had built-up dirt and debris in the tile cracks which appeared black in color. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized. 2. Observation on 3/12/24 at 4:43 PM showed an "EZ Way" sit to stand mechanical lift positioned in the hallway, outside room #35. The lift had dirt and debris built-up on the standing platform which appeared black in color. 3. Observation on 3/12/24 at 4:46 PM showed a heater vent cover in room #40 which had visible rust and damaged brackets sticking out. The damaged brackets had sharp edges visibly noticeable. 4. Observation on 3/12/24 at 4:48 PM showed the carpet in the owl creek common area was worn down and appeared shiny from wear. The area was black in color. Further observation showed the tan and black couch had visible discoloration on the seating area and tears in the cushions. 5. Observation on 3/12/24 at 4:50 PM showed the hand rails in the main dining room were discolored and the sealant had been worn away, which created a porous surface, and the rails	F 921	F921 Corrective Action Porous surfaces on handrails outside room 35, Main Dining Room, outside room 16, outside room 27 have been sealed and made cleanable surface. Floor tiles outside soiled utility room and room 2 have been sealed/fixed. EZ life cleaned. Heater vents in room 40, hallway in the unit x2 have been fixed. Carpet in Owl Creek to be repaired. Tan/black couch has been removed. Urine smells outside of room 16 and 27 have been eliminated. Transitions between unit and front hall, rooms 29,2,3,4, and 10 have been fixed. Handrails outside room 16 and Purple Sage Dining Room have been fixed. Identification of Others Initial audit completed by ED/Designee of environmental concerns and other environmental issues have been fixed and/or cleaned for safety and sanitation. Systemic Changes Education provided by the ED to current staff related to environmental safety and cleanliness. Ongoing audits completed by the ED/Designee weekly for three months to assess safety and cleanliness. Monitoring for Compliance Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.	

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F 921	Continued From page 34	F 921		

could not be effectively sanitized.

6. Observation on 3/12/24 at 4:53 PM showed a urine smell was present in the hallway near room #16. There were no residents present in the area. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized.

7. Observation on 3/12/24 at 4:53 PM showed the transition between the secure unit and the hall way had built-up dirt and debris which was black in color.

9. Observation on 3/12/24 at 4:55 PM showed a urine smell was present in the hallway near room #27. There were no residents present in the area. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized.

10. Observation on 3/12/24 at 4:55 PM showed built-up dirt and debris in the transition between the hallway and room #29 which appeared black in color.

12. Observation on 3/12/24 at 4:56 PM showed broken tiles with built-up dirt and debris in the transition between the hallway and room #2 which appeared black in color.

13. Observation on 3/12/24 at 4:56 PM showed built-up dirt and debris in the transition between the hallway and room #3 which appeared black in color.

14. Observation on 3/12/24 at 4:57 PM showed

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 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATION 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 921	Continued From page 35	F 921		

built-up dirt and debris in the transition between the hallway and room #4 which appeared black in color.

15. Observation on 3/12/24 at 4:57 PM showed built-up dirt and debris in the transition between the hallway and room #10 which appeared black in color.

16. Interview with the administrator on 3/14/24 at 11:05 AM revealed she was aware of some cleanliness concerns and the facility was in the process of ending the contract with the current housekeeping agency. In addition, the facility had plans for some upgrades which included the carpet in the television area. She revealed the facility was aware of the condition of the handrails revealed she planned to request for new handrails because attempts to sand and stain took a long time.

17. Observations with maintenance director and housekeeping manager on 3/14/24 beginning at 11:15 AM showed a heater vent cover in the secure unit which was pulled away from the wall, which created a gap large enough for residents to place their hands, and was damaged in a way the vent cover had sharp edges. A second heater vent cover, near the emergency exit, was dented on one side which created a protruding metal angle sticking out and was sharp. In addition, there was a chipped area in the wood hand rail near room #16 and a chipped area in the wood hand rail near the purple sage dining room, which created sharp edges. Interview with the maintenance director and housekeeping supervisor, during the observations, confirmed the hand rails could not be effectively sanitized. It was confirmed the identified transitions were not

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 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATION 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 921	Continued From page 36 cleaned appropriately. The housekeeping supervisor revealed they could not clean the transition into the secure unit due to the doors sounding an alarm if they are open for too long. They revealed there was a plumbing leak on owl creek and the discoloration outside the soiled utility room was due to the leak. Further interview confirmed the maintenance had attempted to sand and seal hand rail; however, the process was very time consuming to complete. Further interview revealed the damaged heater vent cover and hand rails created a safety risk to residents.	F 921		