STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/23/25 through 6/26/25. Also reviewed in the course of the survey were complaint intakes: WY00004235, WY00004410, WY00004411, and WY00004459. The following common abbreviations are used throughout this document: DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimun Data Set BIMS: Brief Interview for Mental Status URI: Upper Respiratory Infection UTI: Urinary Tract Infection Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, and staff	F0558	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.	07/21/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0558 SS = D	Continued from page 1 and resident interview, the facility failed to ensure accommodation of resident needs for 1 of 14 sample residents (#1) reviewed. The census was 55. The findings were: 1. Review of the admission MDS dated 4/17/25 showed resident #1 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia, spina bifida, and morbid obesity. Further review showed the resident was dependent on staff to roll left and right. All other mobility items were coded as not applicable. The following concerns were identified: a. Interview with the resident on 6/24/25 at 2:07 PM revealed the resident was bed ridden and required a wheelchair to get around. The resident revealed s/he was told the facility would get him/her in a wheelchair and assist the resident to bath in the whirlpool; however, s/he had not been out of bed since admitting to the facility. The resident revealed s/he would like to get out of bed and sit in the chair. Observation at that time showed there was no wheelchair in the room or in the hall near the resident's room. b. Interview with the social services director on 6/26/25 at 9:15 AM revealed he had not received any information about the resident's desire to get up or his/her bathing preferences. c. Interview with the facility administrator and DON on 6/26/25 at 9:30 AM revealed the administrator had talked to therapy and thought therapy was trying to get in touch with the resident's family to obtain his/her wheelchair. They confirmed bathing was part of the reason they were attempting to get the wheelchair. They revealed they have a shower chair; however, the resident does not have good trunk control and his/her personal wheelchair was designed for him/her. They confirmed the resident had not been out of bed since admitting to the facility. d. Interview with the regional clinical director on 6/26/25 at 12:10 PM revealed she talked to the therapy department to see if the resident was safe to sit in a wheelchair the facility had available. Further interview revealed therapy spoke with the resident and s/he was going to talk to his/her family about his/her	F0558	Continued from page 1 Corrective Action: Therapy admitted resident #1 and a w/c was found for resident #1 to use in house. Identification of Others: IDT will conduct an initial random audit via ECR, (Empres Care Rounds) to assess other residents who may have experienced or are experiencing issues with resident rights. Systemic Changes: Social Service Director/Designee will educate current staff related to resident rights. IDT will conduct ongoing audits via the ECR, (Empres Care Rounds) process at least weekly times 12 weeks by DNS/Designee to assess for compliance. Monitoring for Compliance: Social Service Director/Designee will report results of initial and ongoing audits to be monitored via the QAPI process monthly times at least three months for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0558 SS = D	Continued from page 2 personal chair.	F0558		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	Corrective Actions: Housekeeping has cleaned areas with urine smell in hallway near assisted dining room, assisted dining room, and near rooms 31-32. Housekeeping has cleaned resident #13s room. Identification of Others: Housekeeping Supervisor observed areas of the building for offensive smells and housekeeping have addressed the areas. Systemic Changes: DNS/Designee provided education regarding offensive smells in the residents' environment. Ongoing environmental audits to be completed by environmental services/designee weekly for at least 12 weeks to assess for offensive smells. Monitoring for Compliance: Housekeeping Supervisor/Designee will report results of initial and ongoing audits to be reviewed via the QAPI process monthly times at least three months for further recommendations.	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0584 SS = E	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure a clean environment free of odors in 1 of 4 resident care units. The census was 55. The findings were: 1. Observation on 6/23/25 at 3:06 PM revealed a strong urine odor was present on the hallway near the assisted dining room. 2. Observation on 6/24/25 at 8:37 AM revealed a strong urine odor was present near rooms 31 and 32. 3. Observation on 6/25/25 at 10:26 AM revealed resident #13's room smelled strongly of urine. Staff provided assistance to the resident and the resident left the room; however, the odor remained present in resident's room. 4. Observation on 6/26/25 at 8:10 AM revealed a strong urine odor was present in the assisted dining area. 5. Interview with the facility administrator on 6/26/25 at 9:36 AM revealed the facility was aware of the strong urine odors and revealed the odor had gotten better; however, it still needed improvement. Further interview revealed the facility had been discussing an alternate soiled linen storage on the hall.	F0584		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by:	F0679	Corrective Actions: Activities Director has updated activities care plan for resident #1 and resident #43. Identification of Others: Activities Director/Designee has completed activities care plan audit, specifically for 1:1 resident participation and adjusted care plans as indicated. Systemic Changes: Administrator/Designee educated Activities Director on activities care plans and 1:1 activity needs of individual residents. Activities Director/Designee will conduct ongoing audits 2 times per week for at least 12 weeks to assess for further activity concerns. Monitoring for Compliance: Activities Director will report results of initial and ongoing audits to be reviewed via the QAPI process monthly times at least	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0679 SS = D	Continued from page 4 Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure individual activities of preference were provided to 2 of 3 sample residents (#1, #43) reviewed for activities. The findings were: 1. Review of the admission MDS assessment dated 4/17/25 showed resident #1 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included paraplegia, spina bifida, and morbid obesity. Further review showed the resident indicated it was very important to have books, newspapers, and magazines to read, music to listen to, and to go outside to get fresh air when the weather was good and s/he was dependent on staff to roll left and right. All other mobility items were coded as not applicable. The following concerns were identified: a. Interview with the resident on 6/24/25 at 2:07 PM revealed the resident was bed ridden and wanted to get up to do things; however, s/he did not have a wheelchair at the facility. S/he revealed s/he was told the facility was going to get him/her a wheelchair; however, they had not gotten one. S/he revealed the facility staff told him/her there was not enough people available to get up. S/he revealed she was unable to go to activities and s/he felt the facility needed more people to go to resident rooms and talk to residents. Observation at that time showed no evidence of a wheelchair in the resident's room or in the hall near the resident's room. b. Review of the resident's activity participation record from 4/12/25 through 6/25/25 showed the resident did not participate in any of the 73 documented group activities and received 1 to 1 activities on 5 days out of 73 days, on 4/16, 4/23, 6/11, 6/18, and 6/20. All other documented activities were indicated as independent. 2. Review of the quarterly MDS assessment dated 5/29/25 showed resident #43 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder and depression. Review of the admission assessment dated 9/25/24 showed the resident felt it was very important to listen to music, have books, newspapers, and magazines to read, be around pets, and keep up with the news. The following concerns were identified:	F0679	Continued from page 4 three months for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0679 SS = D	Continued from page 5 a. Interview with the resident on 6/24/25 at 8:41 AM revealed there were no activities at the facility that s/he enjoyed participating in. b. Review of the activity participation record from 3/22/25 through 6/25/25 showed the resident participated in 1 out of 92 documented group activities, on 3/24/25, and received a 1 to 1 activity on 2 days out of 94 days, on 4/1/25 and 5/25/25. All other documented activities were indicated as independent. 3. Interview with the activities director on 6/26/25 at 8:26 AM confirmed resident #1 was bed bound and revealed she went to see the resident twice per week. She confirmed the documented activity participation for resident #1 and resident #43 did not reflect 1 to 1 activities being performed twice per week. She revealed when resident #1 admitted to the facility, s/he had a lot of family visits and the resident was "picked back up" for 1 to 1 activities when family stopped coming as frequently. The activity director revealed resident #43 was a "night person" and she revealed there were no activities for residents at night. She revealed the activities the facility does for younger residents included karaoke, happy hour, and scary movie nights. Further interview revealed resident #43 has participated in scary movie nights; however, neither resident #1 or resident #43 participated in karaoke or happy hour. 4. Review of the facility policy titled "Activity Program" last revised July 2015 showed "...5. Activities include individual, small and large group, one-on-one, and independent activities to meet resident's needs, abilities, and interests. For residents confined to, or who choose to, remain in their room, the Activity Department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests..."	F0679		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689	"Past Noncompliance - no plan of correction required"	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0689 SS = D	Continued from page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interview, resident interview, representative interview, and policy review the facility failed to ensure residents were safe for 1 of 2 residents (#7) reviewed for elopement. Corrective measures were implemented prior to the survey and compliance was determined to be met on 6/6/25. The findings were: 1. Review of the medical record for resident #7 showed the 4/11/25 admission MDS assessment had a BIMS score of 2 out of 15 which indicated the resident had severe cognitive impairment, as well as verbal behaviors towards others. S/he had a diagnosis of dementia, moderate, with other behavioral disturbance, as well as alcohol abuse, tobacco use, and nicotine dependence, cigarettes. a. The Elopement risk evaluation performed on 4/7/25 showed the resident was not an elopement risk. On 5/22/25 the resident was an elopement risk, and had left the facility without staff knowing. b. The care plan initiated on 4/14/25, showed the resident was an elopement risk/wanderer related to history of attempts to leave the facility unattended, impaired safety awareness, and verbalized wanting to go home. c. Review of a progress notes showed "5/22/25 17:14 [5:14 PM] Resident was noticed missing at 330pm. Resident has been going outside and sitting in the front most of the day because the weather has been pleasant. Resident did not have any voiced wants to leave during that time. Staff noticed that resident was not outside, nor in [his/her] room. Called overhead, but unable to find resident. Staff went out to search for resident in private vehicles, on foot, and searched the building and all rooms. Local law enforcement was called and a report was filed. Approximately 15 minutes later, resident was found walking back towards the	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0689 SS = D	Continued from page 7 facility ... When asked the resident where [s/he] went, [s/he] stated [s/he] walked up to the store to pick up some Copenhagen, which resident did have in [his/her] possession. This writer reminded resident that [s/he] forgot to let us know that [s/he] was leaving and [s/he] replied, "oh yeah, I forgot"." d. Review of a progress note dated 5/30/25 at 11:45 AM showed "It was found that [resident name] was not in [his/her] room around 1015AM. An elopement alert was announced, and all staff searched the whole building for [resident name]. Other staff was assigned to start looking outside of the building. While searching [residents name] room, staff found the wanderguard on the floor. [Name of city] Police were notified around 1020am after initial search was completed. Staff found resident walking up the main street around 1035am, unharmed. Staff brought [resident name] back to the facility, but [s/he] refused a full body skin assessment. [Resident's name] was offered a meal and was placed on 1:1 r/t [related to] [him/her] taking [his/her] wanderguard off." Review of a progress note dated 6/11/25 at 1:41 PM showed, "This writer spoke with daughter and [ex-spouse] regarding resident's current status. Resident remains on 1 on 1 while awake. Resident is offered to go outside the front and in the courtyard multiple times per day with staff. Resident is offered activities, but usually refuses, except [s/he] likes to watch TV in the TV room. Multiple staff members engage resident in conversations as a distraction when resident talks about going home, which resident does more and more often each day. Resident will become verbally aggressive towards staff when [s/he] feels like [s/he] is being "watched", so 1 on 1 will give resident [his/her] space and privacy but knows resident's location at all times. Resident continues to be a high elopement risk, but is not suitable for the secure unit because of the space being small and [s/he] feels enclosed even with the secured courtyard. Will continue to monitor." 2. Observation 6/23/25 at 4:32 PM showed the resident out front of the building, sitting on a bench. S/he was upset that they made him/her come back in. Other observations during the survey showed 1 on 1 staff were within range of the resident during the day. The resident was observed sitting on the bench in front of the building multiple times throughout the survey. Interview with the resident on 6/24/25 at 10:28 AM revealed s/he likes to be outside no matter the weather. S/he used to be a carpenter and likes to be outdoors.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0689 SS = D	Continued from page 8 3. Interview with the resident representative on 6/24/25 at 3:06 PM revealed the resident liked to spend time outdoors. She stated the facility was working with her for a more appropriate placement in another facility for the resident. 4. Review of the Performance Improvement Plan (PIP) showed the following: 1. Identified Area for Assessed Improvement: Actual Elopements, High Risk Elopements and Elopement Monitoring. 2. Plan, what is being done: Elopement Risk Audit, Wanderguard System, Unit Placement as needed, and Education. 3. Action Steps to Implement Plan was Audit of High-Risk Elopement, Audit Wanderguards, Update Care Plans, Audit Elopement Evaluations, and Audit/Update Elopement Books. 4. Objective Measures to Evaluate Effectiveness: Initial Risk Assessment upon Admission, Daily Wanderguard Checks for function and placement in TARS, and Weekly Audits of Residents who are High-Risk. The plan was completed on 6/6/25. The staff Inservice Education showed it was completed on 5/27/25 at 2:30 PM. 5. Interview with the DON on 6/26/25 at 12:04 PM revealed the resident had eloped, and a PIP and staff education had been completed. 6. Review of policy "Elopement/Wandering" undated February 2025 showed "...4. Based on the results of the Elopement/Exit-Seeking Evaluation, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented. The care plan addresses the resident's wandering behavior, potential to exit Center, and/or actual episodes of elopement and the measures taken to manage those behaviors."	F0689		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More	F0759	Corrective Action: Nurses educated by DNS/Designee to	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0759 SS = D	Continued from page 9 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, policy and procedure review, and manufacturer recommendation review, the facility failed to ensure medication error rates were not greater than 5% during medication administration for 1 of 4 sample residents (#3) observed during medication administration. The medication error rate was 7.69%, 2 out 26 observations. The findings were: 1. Observation on 6/25/25 at 9:34 AM showed LPN #1 prepared 7 medications for resident #3 which included potassium chloride (mineral supplement) 20 meq (milliequivalents) tablet and duloxetine hydrochloride (antidepressant) 40 mg (milligrams) capsule. Further observation showed the LPN broke open the duloxetine capsule and placed it in a medication cup, then crushed the potassium chloride tablet with other medications before adding it to the medication cup. The LPN added applesauce and administered the medications to resident #3. Review of the physician orders for the resident showed an order "May crush meds unless contraindicated" dated 11/6/2014, duloxetine hydrochloride delayed release particles 40 mg give 1 capsule by mouth one time a day dated 2/1/25, and potassium chloride extended release 20 meq give 10 meq by mouth one time a day dated 4/2/25. The following concerns were identified: a. Review of the medication label for Cymbalta (duloxetine hydrochloride) delayed release last revised on 10/2010 showed "...Cymbalta should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents be sprinkled on food or mixed with liquids..." b. Review of the medication label for potassium chloride extended release dated 2013 showed "...tablets are to be swallowed whole without crushing, chewing or	F0759	Continued from page 9 not crush medications for resident #3 or to seek alternate methods for administration. Identification of Others: DNS/Designee completed initial audit of other residents requiring crushed medications to validate medications are crushed per orders. Orders completed as needed. Systemic Changes: DNS/Designee educated nurses and Medication Aides regarding appropriate medication administration. Ongoing audits to be completed by DNS/Designee to monitor for compliance with medication techniques weekly for at least 12 weeks. Monitoring for Compliance: DNS/Designee will report results of initial and ongoing audits to be reviewed via the QAPI process monthly times at least three months for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0759 SS = D	Continued from page 10 sucking the tablets..." 2. Review of the facility policy provided by the DON and titled "Medication Administration General Guidelines" dated 01/21 showed "...5. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber...b. Long-acting, extended release or enteric coated dosage forms should generally not be crushed; an alternative should be sought..."	F0759		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary 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, policy and procedure review, and the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. The census was 55. The findings were: 1. Observation on 6/25/25 beginning at 9:43 AM showed cook #1 prepared a pan of vegetables, doffed her	F0812	Corrective Action: Hand Sanitizer removed from the kitchen. Identification of Others: No others were affected by the deficiency. Systemic Changes: CDM/Designee educated all dietary staff on the use of hand sanitizer in the kitchen. Ongoing audits will be completed by CDM/Designee 2x/week for at least 12 weeks to validate kitchen staff knows policy on handwashing in the kitchen and kitchen staff are following the policy. Monitoring for Compliance: CDM/Designee will report results of initial and ongoing audits to be reviewed via the QAPI process monthly times at least three months for further recommendations.	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0812 SS = E	Continued from page 11 gloves, and placed the pan in the oven. At 9:54 AM she sanitized her hands with Purell gel hand sanitizer, donned gloves and prepared a salad. At 10:09 AM she removed raw meat that was wrapped in plastic from the refrigerator, donned gloves, removed and threw away the meat wrapping, doffed gloves, sanitized hands with gel sanitizer, and seasoned the meat. At 10:19 AM she washed her hands with soap and water. 2. Interview with cook #1 on 6/25/25 at 12:27 PM confirmed she used hand sanitizer if she did not wash her hands in between tasks. 3. Interview with the dietary manager on 6/25/25 at 12:28 PM revealed it was his first time to hear they should not use hand sanitizer in the kitchen. Further interview revealed staff usually used hand sanitizer between gloves after they already washed their hands. 4. Review of the facility policy titled "Handwashing" and last updated March 2016 showed "...Antimicrobial gels cannot be used in place of proper handwashing techniques in a foodservice setting..." 5. According to the 2022 FDA Food Code showed "2-301.16 Hand Antiseptics (A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following: (a) Be an APPROVED drug that is listed in the FDA publication Approved Drug Products with Therapeutic Equivalence Evaluations as an APPROVED drug based on safety and effectiveness; or (b) Have active antimicrobial ingredients that are listed in the FDA monograph for OTC Health-Care Antiseptic Drug Products as an antiseptic handwash, and (2) Consist only of components which the intended use of each complies with one of the following: (a) A threshold of regulation exemption under 21 CFR 170.39 -Threshold of regulation for substances used in FOOD-contact articles; Pf or (b) 21 CFR 178 - Indirect FOOD Additives: Adjuvants, Production Aids, and Sanitizers as regulated for use as a FOOD ADDITIVE with conditions of safe use, or, (c) A determination of generally recognized as safe (GRAS). Partial listings of substances with FOOD uses that are GRAS may be found in 21 CFR 182 - Substances Generally Recognized as Safe, 21 CFR 184 - Direct FOOD Substances Affirmed as Generally Recognized as Safe, or 21 CFR 186 - Indirect FOOD Substances Affirmed as Generally Recognized as Safe for use in contact with FOOD, and in FDA's	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0812 SS = E	Continued from page 12 Inventory of GRAS Notices, or(d) A prior sanction listed under 21 CFR 181 - Prior Sanctioned FOOD Ingredients, or (e) a FOOD Contact Notification that is effective, and (3) Be applied only to hands that are cleaned as specified under § 2-301.12. (B) If a hand antiseptic or a hand antiseptic solution used as a hand dip does not meet the criteria specified under Subparagraph (A)(2) of this section, use shall be: (1)Followed by thorough hand rinsing in clean water before hand contact with FOOD or using gloves; or (2) Limited to situations that involve no direct contact with FOOD by the bare hands..."	F0812		
F0880 SS = E	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 arrangement based upon the facility assessment conducted according to §483.71 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;	F0880	Corrective Actions: Catheter bag placed on bed and wheelchair for resident #25. Resident #51 expired. O2 tubing placed in bags on concentrators and wheelchairs for resident #27 and resident #29. Identification of Others: DNS/Designee conducted initial audits on residents with catheters and oxygen to assess other residents who may be affected by deficiency. Areas were corrected as needed. Systemic Changes: DNS/Designee educated current staff regarding Disposal of Linen and Trash, Glove use During Medication Pass, Oxygen Tubing Placement, Catheter Bag Placement, and Handwashing between Assisting Residents with Food. Ongoing audits will be completed by DNS/Designee weekly for at least 12 weeks to assess for residents with oxygen and catheters. Ongoing audits will be completed by DNS/Designee weekly for at least 12 weeks to asses staff follow policy for Disposal of Linen and Trash, Glove use During Medication Pass, and Handwashing between Assisting Residents with Food. Monitoring for Compliance: DNS/Designee to report results of initial and ongoing audits to be reviewed via the QAPI process monthly times at least three months for further recommendations.	07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0880 SS = E	Continued from page 13 (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 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, medical record review, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 2 sample residents (#25) reviewed for foley catheters, for 1 of 1 sample resident (#51) with a UTI, for 2 of 2 sample residents (#27, #29) reviewed for respiratory health, for 1 of 4 sample residents (#3) reviewed for medication administration, and during 1 random observation of linen transportation. The findings were:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0880 SS = E	Continued from page 14 Related to foley catheters: 1. Observation on 6/26/25 at 10:34 AM showed resident #25 was in bed, and his/her catheter bag was on the floor and uncovered. 2. Interview with the DON on 6/26/25 at 12:08 PM confirmed when residents were in bed, the catheter bag should be stored below the residents waist on the bed and with a catheter cover bag. 3. Review of the facility policy titled "Catheter and Perineal Care" dated 2022 showed "...ensure that the catheter bag is secured to a non-movable part of a bed or chair, the tubing is not dragging on the floor, and the bag is below the level of the bladder..." Related to UTI: 1. Review of resident #51's medical record showed s/he was diagnosed with pneumonia on 3/21/25 and received Azithromycin 12.5ml (milliliters) by mouth one time a day 3/24/25 through 3/27/25. Further review showed s/he was diagnosed with a UTI on 4/7/25 and received Doxycycline Hyclate 100 mg (milligrams) by mouth 2 times a day for 7 days, 4/7/25 through 4/13/25. 2. Interview on 6/26/25 at 9:08 AM with the resident's representative revealed the resident's tablemate had been ill, and the staff had "gone back and forth" between the resident and his/her tablemate. Further interview revealed the resident became ill with pneumonia, which caused diarrhea and stomach upset, and then the resident became ill with a UTI. 3. Interview on 6/26/25 at 12:08 PM with the DON revealed there were residents in the facility that had URI or pneumonia in mid March. Related to respiratory health: 1. Observation on 6/23/25 at 3:11 PM showed resident #27's oxygen tubing was balled up on tank, with the nasal cannula resting on the concentrator and the concentrator was on, but not in use. Observation on	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0880 SS = E	Continued from page 15 6/25/25 at 5:52 PM showed the resident's oxygen tubing was balled up on top of the concentrator. 2. Observation on 6/24/25 at 10:19 AM showed resident #29's oxygen tubing was hanging on his/her concentrator and the nasal cannula was touching the concentrator. Further observation showed the concentrator was against the wall next the resident's bathroom door. Observation on 6/25/25 at 5:50 PM showed resident's oxygen tubing was hanging on his/her concentrator and the nasal cannula was touching the concentrator. Further observation showed the concentrator was against the wall next the resident's bathroom door. 3. Interview with the DON 6/26/25 at 8:19 AM revealed oxygen tubing should be stored in bags when not in use. 4. Review of the facility policy titled "Respiratory Care: Equipment Care and Handling" last updated November 2018 showed ".... equipment ...Storage & waste ...Nasal Cannula or Face Mask ...Store in mesh bag, paper sack, or in compartment/container between use. Discard in regular waste..." Related to medication administration: 1. Observation on 6/25/25 at 9:34 AM showed LPN #1 applied gloves, opened the medication cart, and began removing medications for resident #3. The LPN removed 4 acidophilus capsules, a duloxetine capsule, and 3 phenytoin capsules by placing them on a wash cloth placed on top of the medication cart. Without removing his gloves, the LPN picked up each capsule and broke them open into a medication cup. The LPN then mixed the broken capsules, crushed medications, and applesauce and then administered the medications to the resident. 2. Interview with the DON on 6/26/25 at 11:56 AM revealed nurses should wash their hands when they are going to be handling medications and she would expect gloves to be changed before touching the medications if other items were touched with the gloves. Related to linen transport: 1. Observation on 6/24/25 at 2:44 PM showed an	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River SNF Operations LLC	**1002 Forest Dr , Riverton, Wyoming, 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
F0880 SS = E	Continued from page 16 unidentified staff member exited room 33 with unbagged soiled linen in her hand. The staff member walked across the hall to the housekeeping closet, was unable to open door, walked toward the end of the hall, and returned to room 33. The linen remained in her ungloved hand during transport. 2. Interview with the DON on 6/26/25 at 11:56 AM revealed soiled linen should be bagged when removed from a resident room. 3. Review of the policy titled "Soiled Laundry and Bedding" dated May 2015 showed "...2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use. 3. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items. 3. Anyone who handles soiled laundry wears protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely) ..."	F0880		