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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Skilled Nursing Community at WLRC	8204 Wyoming State Highway 789 , Lander, Wyoming, 82520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 10/14/25 through 10/15/25. The survey was prompted by complaint intakes WY00004497, 2572110, 2617784, 2625829, 2629593, and 2636020. The following common abbreviations are used throughout this document: RN: Registered Nurse MDS: Minimum Data Set CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F0000	F-0600 Free from Abuse and Neglect CFR(s): 483.12(a)(1) This STANDARD is not met as evidenced by: Based on medical record review, staff interviews, facility incident review, and policy review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 2 of 13 sample residents (#2, #3) reviewed for allegations of abuse. This failure results in physical harm to resident #2 and resident #3. Corrective Action(s): Interventions will be used when residents become verbally aggressive, and staff are to support all residents. Removal of residents expressing aggression, if it can be done safely. Removal of other residents to provide psychosocial support. Staff will provide residents with a variety of individual and group activities. 11/29/2025 The facility reviewed the Prevention of Resident Abuse, Neglect, and Exploitation (SNF) policy (effective 5/14/2025) and found no revisions were necessary. Staff to continue to follow the Prevention of Resident Abuse, Neglect, and Exploitation (SNF) policy (effective 5/14/2025). Staff to be in-serviced on updated Care Plans for Residents #1, #2, and #3 by 11/29/2025. Staff to be in-serviced on appropriate safe and calm environments that residents could access across campus. Staff to be in-serviced on Supporting Residents with Intellectual Disabilities and Behavioral Needs. Staff to remain in the main areas of the home when residents are awake and out of their bedrooms.	11/29/2025
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, facility incident review, and policy review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 of	F0600		

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
Kerry George	Facility Administrator	11/6/2025

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F0600 SS = G	Continued from page 1 13 sample residents (#2, #3) reviewed for allegations of abuse. This failure resulted in actual physical harm to resident #2 and resident #3. The findings were: 1. Review of the quarterly MDS assessment dated 9/9/25 showed resident #2 had a brief interview for mental status score of 14 out 15, which indicated s/he was cognitively intact, and had diagnoses which included schizophrenia and bipolar disorder. Further review showed the resident had physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others on 1 to 3 days during the look-back period. The following concerns were identified: a. Review of a progress note for resident #2 dated 5/14/25 and timed 11:27 PM showed "D: Resident to resident aggression. A:Resident [#1] came out of [his/her] room and wanted in the pantry. Resident said everything needed to be locked due to other resident. [Resident #1] then went back to [his/her] room. Staff reported was in the kitchen making popcorn for resident #2]. Resident came out of [his/her] room and asked to call provider [name]. Other resident came toward [#1] with [his/her] laundry basket. [Resident #1] yelled at other resident to stay away and [resident #2] charged at [him/her] and swung at him. [Resident #1] fought back. (The other resident [#2] threw the basket toward [resident #1]). Nurse was called and separated both residents. No injuries noted. [Resident #2] was on floor as other resident was trying to go after [him/her] (pushing toward [him/her] with [his/her] chair) but reports no injury and was not hit by other resident. Guardians, ROC called. Talked to Social Worker [name] about incident. notified providers and DON by email. P: Nursing to follow up as needed." b. Review of a facility incident report dated 5/14/25 showed resident #1 accused resident #2 of stealing his/her food from the pantry. Resident #2 got angry at the accusation and threw a laundry basket at resident #1. Resident #1 attempted to kick resident #2 and then both residents attempted to hit each other. The residents were in a "bearhug style" and resident #2 attempted to pull resident #1 out of his/her wheelchair. Further review showed no physical injuries were identified. c. Review of a progress note for resident #2 dated 7/14/25 and timed 7:35 AM showed "D: Resident to resident incident. A: Green code was called after this resident went after [resident #1] because [s/he] was yelling insults at another resident and was playing [his/her] music way loud and being disruptive. by staff	F0600	**F-0600** **Free from Abuse and Neglect** **CFR(s): 483.12(a)(1)** **(Continued)** Resident #1 was assessed by the team for behavioral symptoms, and the Care Plan was updated to include interventions. Staff are to acknowledge the resident's emotions, ask open-ended questions, actively listen, and provide positive feedback. Allow the resident to discuss his feelings in a safe and calm environment. Staff are to provide positive feedback, active listening, validation, and refrain from challenging the resident's own perception. If able, attempt to reorient the resident to time and place. Verbalization of perceived or actual threats helps the resident reduce his anxiety and promotes open communication. Recognize and shut down negative self-talk by the resident. Provide clear expectations of appropriate group behavior, including verbal. If the resident uses foul/derogatory language about other residents, he will be asked to leave the area until he can behave appropriately in the same room with others. Staff will encourage a replacement behavior, such as more engagement with staff, ignoring the other resident(s), focusing on what he can control, and discuss to work through the behavior and return to the group activity. The resident is receiving support from Behavioralists on campus and off-campus counseling support from a community psychiatrist. Resident #2 was assessed by the team for behavioral symptoms, and an updated Care Plan was created to include interventions. Staff to acknowledge the emotions, use open-ended questions, actively listen, and provide positive feedback. Staff will allow him to discuss his feelings in a safe and calm environment. Staff will provide positive feedback through active	

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F0600 SS = G	Continued from page 2 report [resident #2] threw water on [resident #1] through [his/her] doorway and then tried to punch [him/her]. This nurse arrived shortly after green code called. [Resident #2] was actively to hit and kick [resident #1]. [S/He] was redirected by this nurse to create distance and get them calmed down. Another nurse called [name], NP for one time order hydroxyzine 25 mg. there were no injuries noted. P: Nursing to follow up as needed." d. Review of a facility incident report dated 7/14/25 showed at approximately 2 AM, resident # 1 was yelling at resident #2. Resident #1 was calling resident #2 a "Fucking Retard" and stating resident #2 "should die." Resident #1 turned his/her music "full blast" and "started kicking [his/her] door" which upset resident #2. Resident #2 stated s/he "had enough," obtained a pitcher of water, threw the water on resident #1, and "threw punches" at resident #1. The residents ended up in the hallway with resident #2 "holding onto [resident #1]'s shirt trying to punch and kick [him/her]." After the residents were separated, the RN assessed the residents and identified an abrasion to the leg of resident #1 where resident #2 had kicked him/her. e. Review of a progress note for resident #2 dated 9/17/25 and timed 7:32 PM showed "D- Behaviors A- [resident #2] became aggressive towards another resident today. The other resident was calling staff and residents derogatory names and yelling at others. [Resident #2] threw cold water on the other resident then grabbed the other residents glasses off of [his/her] face and threw them onto the floor. A code green was called and Behaviorist [name] took [resident #2] to [his/her] room to help [him/her] calm down, later security also went to [resident #2]'s room and then took [him/her] for a short walk outside. [Resident #2] came back more calm. P- Continue to provide supportive cares." f. Review of a facility incident report dated 9/17/25 showed resident #2 became aggressive towards resident #1 after resident #1 was "calling staff and residents derogatory names and yelling at others. Resident #2 threw cold water on resident #1 then grabbed resident #1's glassess off his/her face and threw them on the floor. Resident #1 stated resident #2 broke his/her glasses; however, witnesses stated resident #2 bent the glasses then resident #1 broke them completely. g. Review of a facility incident report dated 9/25/25 showed resident #1 was calling staff and other residents derogatory names. The resident went to his/her room. Resident #2, who was upset by the name	F0600	**F-0600** **Free from Abuse and Neglect** **CFR(s): 483.12(a)(1)** **(Continued)** listening, offering validation, and refraining from challenging the resident's own perception. If able, attempt to reorient him to time and place. Staff will use reinforcement of positive behaviors and engagement, as well as replacement behaviors. The resident is receiving services with a mental health counselor off campus and has the support of a Behavioralists and Licensed Mental Health Counselor (LMHC) on campus. Resident #3 was assessed, and interventions were implemented in the Care Plan. Activities are available frequently at various locations around campus. Residents will be educated on the importance of safety when entering others' homes. Staff will follow the Care Plan, allowing time for him to process and provide support as needed. Residents will be offered plenty of opportunities for engagement with staff and other residents throughout the day. Monitor Performance: The SNF Interdisciplinary Team (IDT) will conduct a weekly check-in with residents, encompassing their living environment, concerns about housemates, and other relevant aspects. A form will be created for this purpose. Designated team members will check in with residents at least twice a month to ensure that their concerns are being addressed and their voices are being heard. Social Services will conduct weekly safety interviews for one month, then bi-weekly for another month, and once a month for a final month. The Interdisciplinary Team (IDT) will meet monthly to review the Care Plan interventions and ensure they remain effective for the targeted behavior for three (3) months.	

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F0600 SS = G	Continued from page 3 calling, went to resident #1's room, threw a beverage on resident #1, jumped on resident #1, and punched resident #1. 2. Review of the quarterly MDS assessment dated 9/9/25 showed resident #3 long-term and short-term memory was not impaired and had diagnoses which included cerebral palsy, seizure disorder, and anxiety disorder. The resident had no physical or verbal behavioral symptoms directed toward others during the look-back period. Further review showed the resident used a motorized wheelchair. The following concerns were identified: a. Review of a progress note dated 9/19/25 and timed 11:38 PM showed "D:Resident to Resident altercation A: During shift change we received a call by staff about resident to resident altercation. It was unclear by staff at what started the altercation but staff witnessed residents outside sunflower with residents side by side in wheel chairs with [resident #3]'s good side closer to the other resident. Both residents were seen hitting each other before staff could break them up. The other resident has been known to taunt [resident #3] and call [him/her] a retard on several different occasions. Upon assessment [resident #3] has some right eye swelling, and bruising is noted as well as a small scrape. There is also a small pin point size mark on [resident #3]'s right outer thumb with no bleeding visualized. There is a blood blister on right pointer finger and right knuckle that are not related to altercation. Head injury check list was initiated. Resident is alert and able to respond by nodding head and following commands VS and neuro check were all WNL to resident baseline. Resident does report pain to right side of face above eye, Tylenol was administered will continue to monitor for effectiveness. Nursing notified administrator [name] and ROC [name] around 18:50. Guardian notified about altercation " informed Guardian about how the residents were found fighting and that the cause of altercation was unknown, but it was someone that [resident #3] had a history with. Let guardian know about swelling and bruising to eye and small injury on thumb, guardian expressed understanding and stated that [resident #3] can hold a grudge and has a temper. Let guardian know we will continue to follow up with any changes" P: Will continue to monitor." b. Review of an incident report dated 9/19/25 showed resident #1 had returned from a nature ride and was unloaded on the sidewalk in front of his/her house. Resident #3 was driving his/her wheelchair down the sidewalk towards the Sunflower unit as that was where	F0600	**F-0600** **Free from Abuse and Neglect** **CFR(s): 483.12(a)(1)** **(Continued)** How the Facility Will Identify Other Residents Being Affected: Staff will remove any resident from the area if housemates are experiencing altered behavioral symptoms, ensuring the safety and psychosocial support of all residents. Staff will monitor for signs of increased agitation and proactively offer support before a resident's behavior escalates. Responsible Person(s): SNF Administrator, Director of Nursing, and Social Worker The SNF-Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review monthly metrics regarding allegations that did not meet the criteria of abuse, neglect, and mistreatment.	

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F0600 SS = G	Continued from page 4 his friends lived. The incident showed "words were exchanged" by resident #1 and resident #3 "who is non-verbal," and resident #3 hit resident #1 in the head and ran his/her wheelchair into resident #1. Resident #1 hit resident #3 and stated s/he had a right to defend him/herself. The residents were separated and assessed. Further review showed both residents had "minor injuries" that were treated by the facility. c. Interview with CNA #1 on 10/15/25 at 12:01 PM revealed on 9/19/25 resident #1 and 2 other resident had gone on nature ride. The CNA revealed after resident #1 was assisted off the bus, he heard another staff member say "stop it." The CNA revealed when he turned around, he observed resident #1 and resident #3 swinging at each other and observed them hit each other. The CNA revealed when the altercation was over, resident #1 had a scratch on his/her chin and resident #3 had a red area on his/her head and eye. The CNA revealed the following day resident #3 had a "black eye." Further interview revealed resident #1 claimed resident #3 had pushed him/her off the sidewalk and hit him/her. 3. Interview with CNA #2 on 10/15/25 at 10:38 AM revealed resident #3 got along with everyone except resident #1. Following the incident on 9/19/25, the CNA revealed resident #3 was fearful. The CNA revealed she had observed resident #1 resident #3 a "retard" and stated resident #3 would "get mad." She revealed she was unsure what to do with resident #1 because when staff told him/her to stop making statements towards others, resident #1 would increase the statements. The CNA revealed resident #2 had gone after resident #1 because resident #2 was protective of staff and other residents and resident #1 antagonized other residents and staff. 4. Interview with CNA #3 on 10/25/25 at 12:23 PM revealed on 9/25/25 resident #1 was upset when s/he woke up. She revealed the resident was calling people derogatory names. She revealed resident #2 was trying to stay out of it by staying in his/her room. The CNA revealed she asked resident #1 to stop calling others names; however, when s/he was told s/he could not make a phone call, resident #1 got upset and chased after the CNA. The CNA revealed she had called security and when resident #2 came out of his/her room s/he heard the statements resident #1 was making, grabbed some water, and headed to resident #1's room. The CNA revealed by the time she made it to the room, resident #1 was "soaked" and resident #2 was trying to punch resident #1 while resident #1 was hitting resident #2 on top of the head with a television remote. The CNA	F0600		

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F0600 SS = G	Continued from page 5 revealed after the residents were separated, resident #2 was "still angry" and was yelling at resident #1. The CNA revealed resident #1 was "always agitating others" and when staff attempt to redirect him/her, it was not always effective. The CNA revealed resident #2 often stayed in his/her room to avoid resident #1. The CNA revealed once when resident #3 came to the house to visit her, resident #1 stated "When you are done playing with the retard, I need a napkin." The CNA revealed on a different occasion resident #1 stated "Oh my god, you guys play with [him/her] like [s/he] is a fucking 3-year-old" in regards to resident #3. Further interview revealed resident #3 indicated s/he was afraid of resident #1 and when they shared a house, resident #3 would remain in his/her room to avoid resident #1. 5. Interview with RN #1 on 10/15/25 at 11 AM revealed resident #3 was non-verbal and got along with everyone except resident #1 because s/he called resident #3 "retarded." The RN revealed following the altercation on 9/19/25 resident #3 shook his/her head no when asked if s/he was ok, then pointed to his/her arm and head. The RN revealed resident #3 had some scratches and his/her eye was red. The RN revealed resident #1 had other incidents with individuals due to derogatory statements. The RN revealed resident #2 had been in incidents with resident #1 after resident #1 had made derogatory statements to others. 6. Review of the facility policy titled "Prevention of Resident Abuse, Neglect, and Exploitation" dated 5/14/25 showed "...It is the policy and practice of the WLRC that all residents will be protected from abuse and neglect..."	F0600	F-0609 **Reporting of Alleged Violations** **CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)** This STANDARD is not met as evidenced by: *Based on facility incident report review, state survey agency incident database review, staff interview, and policy and procedure review, the facility failed to ensure timely reporting of allegations of abuse for 2 of 13 sample residents (#1, #2) reviewed for allegations of abuse.* Corrective Action(s): Staff to be in-serviced on *Prevention of Resident Abuse, Neglect, and Exploitation (SNF)* policy (effective 5/14/2025), and this will be completed by November 25, 2025. The *Prevention of Resident Abuse, Neglect, and Exploitation (SNF)* policy (effective 5/14/2025) will be re-in-serviced monthly for a total of three (3) months. WLRC will continue to provide reporting guideline training to new employees during new employee orientation and to existing employees during their required annual review classes. WLRC will ensure that reporting information and telephone numbers to call are posted in all residential areas and all other relevant work areas on campus. Along with the weekly staff assignment for Administrator On-Call (AOC) duties, WLRC also assigns a staff member with access to the *WDH OHLS Incident Tracking System* website for reporting purposes. This person will be contacted when incidents need to be posted on the website in a timely manner.	11/29/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not	F0609		

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F0609 SS = D	Continued from page 6 result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on facility incident report review, state survey agency incident database review, staff interview, and policy and procedure review, the facility failed to ensure timely reporting of allegations of abuse for 2 of 13 sample residents (#1, #2) reviewed for allegations of abuse. The findings were: 1. Review of a facility incident report dated 9/27/25 and timed 4 PM showed resident #1 called resident #2 an "asshole" and resident #2 threw a cup of juice on resident #1. 2. Review of the state survey agency incident database showed the incident was reported on 9/30/25 at 8:12 AM, 3 days after the incident occurred. 3. Interview with facility investigator on 10/15/25 at 12:46 PM confirmed the incident was not reported timely. She revealed the incident occurred on a Saturday and at that time, they did not have any staff members who had access to the incident database that worked on the weekends. 4. Review of the facility policy titled "Prevention of Resident Abuse, neglect, and Exploitation" dated 5/14/25 showed "...3. WLRC staff will report the allegation to the Wyoming Healthcare Licensing and Survey (HLS) website immediately, but not later than: Two (2) hours after the allegation is made if the events that cause the allegation involve abuse OR result in serious bodily injury; or Twenty-four (24) hours after the allegation is made, if the events that cause the allegation do not involve abuse AND do not	F0609	**F-0609** **Reporting of Alleged Violations** **CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)** **Continued** Monitor Performance: The SNF Administrator will track staff being re-inserviced over the three (3) month period with training sign-in sheets that staff sign and date. Responsible Person(s): SNF Administrator, Director of Nursing, and Social Worker The SNF-Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review monthly metrics regarding allegations that did not meet the criteria of abuse, neglect, and mistreatment.	

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F0609 SS = D	Continued from page 7 result in serious bodily injury..."	F0609		
F0740 SS = G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to ensure necessary behavioral health care and services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 13 sample residents (#1) who was reviewed for behavioral health interventions. This failure resulted in actual harm to resident #1. The findings were: 1. Review of the quarterly MDS assessment dated 9/3/25 showed resident #1 had a brief interview for mental status score of 15 out 15, which indicated s/he was cognitively intact, and had diagnoses which included cerebral vascular accident, non-Alzheimer's dementia, seizure disorder, traumatic brain injury, anxiety disorder, depression, and psychotic disorder. Further review showed the resident had verbal behavioral symptoms directed toward others 1 to 3 days during the look-back period. Review of the care plan for resident #1 dated "4/3/2024-Present" showed "Behavioral Symptoms: Baseline Behaviors [resident #1] has exhibited verbal and physical behavioral symptoms directed at self and others." The interventions included "When [resident #1] becomes frustrated with other residents, staff will support [resident #1] to plan to ignore and work with them when [s/he] encounters them, rather than calling them names. Staff will offer redirection with preferred activities. Staff will contact nursing if interventions are not effective. Nursing will contact provider if further interventions such as one on one are necessary (which needs to be ordered by the provider). Respond in a calm voice; maintain eye contact. Remove from area if [resident #1] is verbally abusive to others. Escalated	F0740	**F-0740** **Behavioral Health Services** **CFR(s): 483.40** This STANDARD is not met as evidenced by: *Based on observation, resident and staff interview, and record review, the facility failed to ensure necessary behavioral health care and services were provided to attain or maintain the highest practicable physical, Mental and psychosocial well-being for 1 of 13 sample residents (#1) who was reviewed for behavioral health interventions. The failure resulting in actual harm to resident #1.* Corrective Action(s): The facility reviewed the *Prevention of Resident Abuse, Neglect, and Exploitation (SNF)* policy (effective 5/14/2025) and found no revisions to be made. Staff to continue to follow the *Prevention of Resident Abuse, Neglect, and Exploitation (SNF)* policy (effective 5/14/2025). Behavioral health services will be provided by qualified staff who possess the necessary competencies and skills to deliver appropriate care to residents through comprehensive assessments and Care Plans. Staff to be in-serviced on *Supporting Residents with Intellectual Disabilities and Behavioral Needs*. Behavioral issues that arise among residents are managed according to strategies documented in the Care Plan, and behavioral interventions approved by the Interdisciplinary Team (IDT) and behavioral staff members.	11/29/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Skilled Nursing Community at WLRC	8204 Wyoming State Highway 789 , Lander, Wyoming, 82520

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F0740 SS = G	Continued from page 8 behavior management: If [resident #1] is physically or verbally aggressive towards other residents, including threat of harm to other residents, [resident #1] may be assisted from the vicinity of other residents, for other residents' safety." The following concerns were identified: a. Review of a facility incident report dated 5/14/25 showed resident #1 accused resident #2 of stealing his/her food from the pantry. Resident #2 got angry at the accusation and threw a laundry basket at resident #1. Resident #1 attempted to kick resident #2 and then both residents attempted to hit each other. The residents were in a "bearhug style" and resident #2 attempted to pull resident #1 out of his/her wheelchair. Further review showed no physical injuries were identified. b. Review of a facility incident report dated 6/25/25 showed resident #1 was in an "elevated behavior due to outside stimuli" and was being aggressive physically and verbally towards other residents in the unit. There were no injuries or outcomes identified. c. Review of a facility incident report dated 7/14/25 showed at approximately 2 AM, resident #1 was yelling at resident #2. Resident #1 was calling resident #2 a "Fucking Retard" and stating resident #2 "should die." Resident #1 turned his/her music "full blast" and "started kicking [his/her] door" which upset resident #2. Resident #2 stated s/he "had enough," obtained a pitcher of water, threw the water on resident #1, and "threw punches" at resident #1. The residents ended up in the hallway with resident #2 "holding onto [resident #1]'s shirt trying to punch and kick [him/her]." After the residents were separated, the RN assessed the residents and identified an abrasion to the leg of resident #1 where resident #2 had kicked him/her. d. Review of a facility incident report dated 9/17/25 showed resident #2 became aggressive towards resident #1 after resident #1 was "calling staff and residents derogatory names and yelling at others. Resident #2 threw cold water on resident #1 then grabbed resident #1's glasses off his/her face and threw them on the floor. Resident #1 stated resident #2 broke his/her glasses; however, witnesses stated resident #2 bent the glasses then resident #1 broke them completely. e. Review of an incident report dated 9/19/25 showed resident #1 had returned from a nature ride and was unloaded on the sidewalk in front of his/her house. Resident #3 was driving his/her wheelchair down the sidewalk towards the Sunflower unit as that was where	F0740	**F-0740** **Behavioral Health Services** **CFR(s): 483.40** **Continued** The resident is receiving support from Behavioralists on campus and off-campus counseling support from a community psychiatrist pertaining to replacement behaviors, ignoring the other residents, and focusing on what he can control. Staff will provide positive feedback through active listening, offer validation, and refrain from challenging the resident's own perception. The resident is receiving services with a mental health counselor off campus and has the support of a behavioral specialist and Licensed Mental Health Counselor (LMHC) on campus. Monitor Performance: The SNF Interdisciplinary Team (IDT) will conduct a weekly check-in with residents, encompassing their living environment, concerns about housemates, and other relevant aspects. A form will be created for this purpose. Responsible Person(s): SNF Administrator, Director of Nursing, Social Worker, and campus behavioral staff members. The SNF-Quality Assurance Performance Improvement Committee (SNF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events as presented by monthly reporting to improve the detection of events, optimize cause analysis, and build best practices. The committee will review monthly metrics regarding allegations that did not meet the criteria of abuse, neglect, and mistreatment.	

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F0740 SS = G	Continued from page 9 his friends lived. The incident showed "words were exchanged" by resident #1 and resident #3 "who is non-verbal," and resident #3 hit resident #1 in the head and ran his/her wheelchair into resident #1. Resident #1 hit resident #3 and stated s/he had a right to defend him/herself. The residents were separated and assessed. Further review showed both residents had "minor injuries" that were treated by the facility. f. Review of a facility incident report dated 9/25/25 showed resident #1 was calling staff and other residents derogatory names. The resident went to his/her room. Resident #2, who was upset by the name calling, went to resident #1's room, threw a beverage on resident #1, jumped on resident #1, and punched resident #1. g. Review of a facility incident report dated 9/27/25 showed resident #1 provoked resident #2 by getting in front of him/her and calling resident #2 an "asshole." Resident #2 became escalated and threw juice and the cup at resident #1 and called resident #1 a "fucking asshole." 2. Interview with CNA #1 on 10/15/25 at 12:01 PM revealed on 9/19/25 resident #1 and 2 other resident had gone on nature ride. The CNA revealed after resident #1 was assisted off the bus, he heard another staff member say "stop it." The CNA revealed when he turned around, he observed resident #1 and resident #3 swinging at each other and observed them hit each other. The CNA revealed when the altercation was over, resident #1 had a scratch on his/her chin and resident #3 a red area on his/her head and eye. The CNA revealed the following day resident #3 had a "black eye." Further interview revealed resident #1 claimed resident #3 had pushed him/her off the sidewalk and hit him/her. 3. Interview with CNA #2 on 10/15/25 at 10:38 AM revealed resident #3 got along with everyone except resident #1. Following the incident on 9/19/25, the CNA revealed resident #3 was fearful. The CNA revealed she had observed resident #1 resident #3 a "retard" and stated resident #3 would "get mad." She revealed she was unsure what to do with resident #1 because when staff told him/her to stop making statements towards others, resident #1 would increase the statements. The CNA revealed resident #2 had gone after resident #1 because resident #2 was protective of staff and other residents and resident #1 antagonizes other residents and staff. The CNA was unsure what interventions were effective to redirect resident #1.	F0740		

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F0740 SS = G	Continued from page 10 4. Interview with CNA #3 on 10/25/25 at 12:23 PM revealed on 7/14/25 resident #1 was upset when s/he woke up. She revealed the resident was calling people derogatory names. She revealed resident #2 was trying to stay out of it by staying in his/her room. The CNA revealed she asked resident #1 to stop calling others names; however, when s/he was told s/he could not make a phone call, resident #1 got upset and chased after the CNA. The CNA revealed she had called security and when resident #2 came out of his/her room s/he heard the statements resident #1 was making, grabbed some water, and headed to resident #1's room. The CNA revealed by the time she made it to the room, resident #1 was "soaked" and resident #2 was trying to punch resident #1 while resident #1 was hitting resident #2 on top of the head with a television remote. The CNA revealed after the residents were separated, resident #2 was "still angry" and was yelling at resident #1. The CNA revealed resident #1 was "always agitating others" and when staff attempt to redirect him/her, it was not always effective. The CNA revealed resident #2 often stayed in his/her room to avoid resident #1. The CNA revealed once when resident #3 came to the house to visit her, resident #1 stated "When you are done playing with the retard, I need a napkin." The CNA revealed on a different occasion resident #1 stated "Oh my god, you guys play with [him/her] like [s/he] is a fucking 3-year-old" in regards to resident #3. Further interview revealed resident #3 indicated s/he was afraid of resident #1 and when they shared a house, resident #3 would remain in his/her room to avoid resident #1. 5. Interview with RN #1 on 10/15/25 at 11 AM revealed resident #3 was non-verbal and got along with everyone except # resident #1 because s/he called resident #3 "retarded." The RN revealed following the altercation on 9/19/25 resident #3 shook his/her head no when asked if s/he was ok, then pointed to his/her arm and head. The RN revealed resident #3 had some scratches and his/her eye was red. The RN revealed resident #1 had other incidents with individuals due to derogatory statements. The RN revealed resident #2 had been in incidents with resident #1 after resident #1 had made derogatory statements to others. 6. Interview with CNA #4 on 10/15/25 at 11:21 AM revealed resident #1 called the other residents retards and upsets the other resident. The CNA revealed resident #2 gets really upset and has a hard time	F0740		

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F0740 SS = G	Continued from page 11 calming down. The CNA revealed resident #1 will make derogatory statements "for hours" and the staff don't have any interventions to get resident #1 to stop. 7. Interview with CNA #5 on 10/15/25 at 11:39 AM revealed resident # 1 called other derogatory names and upset other residents. The CNA revealed the only intervention was to tell the resident to stop which was effective sometimes and wasn't effective other times.	F0740		