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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River Rehabilitation and Wellness	**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 complaint survey was conducted by Healthcare Licensing and Surveys on 2/3/26 through 2/5/26. The survey was prompted by complaint intake #2726851. The following common abbreviations are used throughout this document: DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F0000		02/24/2026
F0684 SS = D	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 medical record review, staff interview, facility medication error report review, and in-service education review, the facility failed to ensure medications were available for 1 of 4 sample residents reviewed for medication administration. Corrective measures were implemented prior to the survey and compliance was determined to be met on 1/21/26. The findings were: 1. Review of the quarterly MDS assessment dated 11/24/25 showed resident #4 had a brief interview for mental status score of 13 out 15, which indicated the resident was cognitively intact, and had diagnoses	F0684	"Past Noncompliance - no plan of correction required"	01/22/2026

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

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F0684 SS = D	Continued from page 1 which included paraplegia, cervicalgia, spina bifida, and morbid obesity. Further review showed the resident received insulin injections on 1 day during the 7-day look-back period. Review of the physician orders showed the resident was ordered alendronate sodium (bisphophonate) 70 milligrams (MG) per 75 milliliters (ML) by mouth one time per day every seven days for osteoporosis and Zepbound (tirzeptide) 5 MG per 0.5 ML inject 7.5 ML subcutaneously on time per day every Monday related to morbid obesity. The following concerns were identified: a. Review of the resident's medication administration record (MAR) for August 2025 showed the alendronate sodium was not administered on 2 out 3 opportunities for administration and was marked “on order from pharmacy" on 8/15/25 and 8/22/25. b. Review of the resident's MAR for September 2025 showed the alendronate sodium was not administered on 2 of 4 opportunities for administration and was marked "on order from pharmacy on 9/5/25 and 9/26/25. c. Review of the resident's MAR for October 2025 showed the alendronate sodium was not administered on 4 of 5 opportunities for administration and was marked "on order from pharmacy on 10/3/25, 10/10/25, 10/17/25, and 10/24/25. d. Review of the resident's MAR for November 2025 showed alendronate sodium was not administered on 4 of 4 opportunities for administration and was marked "on order from pharmacy on 11/7/25, 11/14/25, 11/21/25, and 11/28/25. e. Review of the resident's MAR for December 2025 showed alendronate sodium was not administered on 3 of 4 opportunities for administration and was marked "on order from pharmacy on 12/5/25, 12/12/25, and 12/19/25. Further review showed the Zepbound was to be administered at a dose of 2.5 mg until 12/1/25, with a start date of 11/9/25. An order for Zepbound 5 mg was ordered from 12/22/25 to the discontinue date of 1/5/26. There was no evidence of an order for Zepbound or administration from 12/1/25 through 12/22/25. f. Review of the resident's MAR for January 2026 showed alendronate sodium was not administered on 4 of 5 opportunities for administration and was marked "on order from pharmacy on 1/9/26, 1/16/26, and 1/30/26 and was marked "other/see progress notes on 1/23/26. g. Review of a physician's consult dated 12/13/25 showed "... Apparently [resident #4] ran out of	F0684		

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F0684 SS = D	Continued from page 2 tirzeptide and one called for a refill, will refill today, reviewed w/ [with] nursing and DON that they need to call our clinics for refills... tolerated the 2.5 mg dose of tirzeptide. SNF [skilled nursing facility] hasn't picked up the alendronate yet, need to do this, reviewed w/ [with] nursing and DON... reviewed with SNF staff need to pick up the alendronate and tirzeptide from [address], do not let [him/her] run out as lapses in tirzeptide can lead to worse side effects..." h. Interview with the resident's physician on 2/4/26 at 10:30 AM revealed he had issues with medications not being available and the facility did not notify him, or the facility did not pick up the medications from the pharmacy. The physician revealed he has communicated with the facility and let them know when medications were ordered, they would be available for pick-up between 24 and 48 hours after they were ordered. Further interview revealed if the medications were not available, he was told the facility could get them from a local pharmacy. i. Interview with the administrator on 2/5/26 at 2:01 PM revealed the facility had identified the alendronate and tirzeptide medication errors on 1/20/26 and performed an audit back 30 days. Further interview revealed a performance improvement plan was implemented. j. Review of an "Inservice Education Summary" dated 1/21/26 showed the training content was "If medication is not received from pharmacy, floor nurse is to contact pharmacy and inquire information regarding medication not being delivered and then notify MD regarding missed dosage of medication. Then document notification in PCC [point click care]." 2. Review of the facility's plan of correction dated 1/21/26 showed the following interventions were implemented as a result of the incident: a. A "Medication Error/Adverse Drug Reaction Report" was completed on 1/21/26 for resident #4's missed Zepbound and Alendronate doses. b. Education was provided to all nurses related to "Medication not Received from Pharmacy" on 1/21/26. c. Audits were implemented on 1/21/26. 3. The implementation of the plan of correction was	F0684		

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F0684 SS = D	Continued from page 3 verified during the survey.	F0684		
F0880 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 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; (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	F0880	1) Corrective Action: Resident #4 was placed on EBPs. 2) Identification of Others: DNS/Designee conducted initial audits on residents with EBP needs to assess other resident who may be affected by deficiency. Areas were corrected as needed. 3) Systemic Changes: DNS/Designee educated current staff regarding EBP policy and procedures. Ongoing audits will be completed by DNS/Designee 1x/week for at least 12 weeks to assess for residents with EBP needs. 4) 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.	02/06/2026

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F0880 SS = D	Continued from page 4 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, record review and policy and procedure review, the facility failed to ensure enhanced barrier precautions were implemented for 1 of 3 sample residents (#4) during wound care. The findings were: 1. Review of a telephone order dated 1/11/26 showed resident #4 had an open wound to his/her sacrum. Review of a progress note dated 1/18/26 and timed 11 PM showed the resident had an open wound to his/her right lower extremity. Review of the hospital discharge summary dated 1/23/26 showed the resident was discharged from hospital on 1/23/26 where s/he was treated for a right lower extremity wound and cellulitis, had an open sacral wound, and a new foley catheter placement. The following concerns were identified: a. Observation of wound care for the resident on 2/5/26 at 9:22 AM showed the DON and LPN #1 entered the resident's room, performed hand hygiene, and donned gloves. At that time, the DON performed perineal care and foley catheter care due to the resident being incontinent of loose stools. The DON doffed her gloves,	F0880		

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F0880 SS = D	Continued from page 5 performed hand hygiene with soap and water, donned clean gloves, removed a dressing to the resident's sacral wound, and cleaned the wound. The DON doffed her gloves and donned clean gloves, applied a clean dressing, doffed her gloves, performed hand-hygiene, and exited the room. No additional personal protective equipment was used during the wound care. b. Interview with the DON on 2/5/26 at 2:06 PM revealed enhanced barrier precautions should be used for all residents with wounds, catheters, and dialysis or other types of ports. Further interview revealed gloves and gowns should be worn for enhanced barrier precautions during wound care and she confirmed resident #4 should have been on enhanced barrier precautions. 2. Review of the policy titled "Transmission-Based Precautions (Isolation)" last updated March 2025 showed "...Enhanced Barrier Precautions (EBP) are designed to reduce transmission of multidrug-resistant organisms (MDROs). EBP involve the use of gowns and gloves by care providers, during high-contact resident care activities. EBP are used when caring for residents with colonization or infection with a targeted and epidemiologically important MDRO, chronic wounds, or indwelling medical device/s..."	F0880		