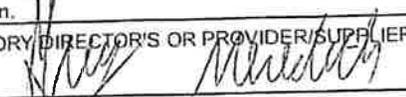


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER <b>Wyoming Veterans' Skilled Nursing Facility</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 Veteran's Lane , Buffalo, Wyoming, 82834</b>	
(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 1/20/26 through 1/23/26. Also reviewed in the course of the survey were complaint intakes #2706313, #2616131, #2580908, and #1902080.  The following common abbreviations are used throughout this document:  CNA: Certified Nursing Assistant  DON: Director of Nursing  RN: Registered Nurse  MDS: Minimum Data Set  Less commonly used abbreviations will be annotated in each deficiency.	F0000	<p><b>All identified deficiencies have been incorporated into a performance improvement plan. These plans will undergo quality assurance assessment, and necessary revisions and implementation steps will be undertaken as required.</b></p> <p>The facility acknowledges and affirms the right of all residents to remain free from abuse and neglect. Following a thorough investigation of the incident, the facility has developed a comprehensive plan of correction designed to assess for additional systemic issues and prevent future occurrences.</p>	2/20/2026
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, incident review, staff	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 ADMIN	(X6) DATE 2-27-2026
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F0600 SS = G	<p>Continued from page 1 interview, and policy and procedure review, the facility failed to protect the residents' right to be free from physical and verbal abuse by a staff member for 1 of 2 sample residents (#3) reviewed for allegations of abuse. This failure resulted in actual harm to resident #3. The findings were:</p> <p>1. Review of the annual MDS assessment dated 12/26/25 showed resident #3 had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included hemiplegia or hemiparesis, anxiety disorder, chronic inflammatory skin condition, and restless leg syndrome. Further review showed the resident had upper and lower extremity impairment on one side and required partial/moderate assistance with toilet hygiene and toilet transfer. The following concerns were identified:</p> <p>a. Interview with the resident on 1/21/26 at 10:11 AM revealed CNA #1 hurt him/her and caused pain while providing care. The resident revealed the CNA did not leave any marks and was no longer employed at the facility.</p> <p>b. Review of a facility incident dated 12/26/25 and timed 2:15 PM showed the on-call nurse reported CNA #1 for yelling and cursing at resident #3 during his/her care. The incident report showed the nurse intervened, telling the CNA "it was enough," causing her to stop and leave. CNA #1 was immediately sent home, removed from the schedule, and instructed not to return pending investigation. The incident report showed resident #3 requested the CNA to no longer care for him/her, management to be notified, and to file a grievance form. The incident report showed resident #3 reported s/he used his/her call light to request help after an incontinence episode and when CNA #1 entered, she insisted the resident receive a shower, which the resident refused. The resident reported an argument escalated, during which the resident "snapped at" CNA #2, who originally answered the call light. The incident report showed CNA #1 then yelled at resident #3, began "scrubbing [him/her] really hard," and was being "intentionally rough." The incident report showed the resident reported asking the CNA #1 to stop and get someone else, which she refused, while continuing to yell. The incident report showed the resident attempted to reach for the call light and the CNA #1 locked the shower chair brakes to prevent him/her from reaching the cord. The incident report showed the nurse entered the room and told the CNA to stop, which ended the interaction. Further review showed the resident reported pain during the incident and soreness</p>	F0600	<p><b>Immediate Action</b> The alleged perpetrator (CNA #1) was immediately removed from the facility and prohibited from returning pending investigation on 12/26/25</p> <p>12/27/25 Resident #3 was interviewed, informed of the CNA's removal, and assessed for injuries (with no visible injury documented). Resident gave approval for travel agency (employer CNA #1), Adult protective services, and ombudsman office to have information regarding the incident</p> <p>12/29/2025 Ombudsman, Adult protective services informed of incident. CNA travel contract terminated with facility. APS office informed facility they would handle police notification and involvement.</p> <p>1/2/2026 Incident reported to the state board of nursing</p> <p>1/7/2026 APS met with resident and notified of police involvement</p> <p>1/21/2026 Police interview conducted with DON</p> <p>1/22/2026 follow-up police interview completed with DON</p> <p>The resident verbalized satisfaction with this immediate resolution of termination of travel CNA and notification of appropriate agencies. The resident continues to be followed by the Psychiatric Nurse Practitioner (Psych NP) to monitor and address any further mental or emotional distress resulting from the occurrence.</p> <p><b>Completion date of immediate action and investigation by outside agencies 1/22/2026</b></p>	

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0600 SS = G	<p>Continued from page 2 following.</p> <p>c. Interview with CNA #2 on 1/23/26 at 8:26 AM revealed on the day of the incident, resident #3 had an issue with loose stools and called for assistance. She revealed she transferred the resident from his/her wheelchair to the shower chair and told the resident they need to transfer in the bathroom. The CNA revealed she found CNA #1 and asked her to help when she was done with what she was doing. At that time, CNA #2 went to get a cleaning cart and when she returned to the resident's room, she heard CNA #1 yelling and arguing with the resident, observed her "scrubbing" the resident and his/her wound, and heard resident #3 say it hurt and to stop, which CNA #1 refused. CNA #2 revealed she heard CNA #1 say "ff [the resident] wanted to be an asshole, she could be an asshole too." and the CNA told the resident s/he "had shit in [his/her] [genitals]." The CNA revealed after she returned to the room, the resident became upset with her and she left the room again. She revealed upon returning to the room again, she heard CNA #1 yell for the resident to stop. CNA #2 revealed she left the room to find the nurse and when the nurse entered the resident's room, the nurse told CNA #1 to stop. CNA #2 revealed following the incident, resident #3 was quiet and mad, and stayed in his/her room. She revealed the resident requested to file a grievance and stated s/he did not want CNA #1 caring for him/her anymore. CNA #2 revealed she felt CNA #1 was being mean and hateful and when they left the room, CNA #2 told CNA #1 she would be mad if they all got in trouble for what CNA #1 had done. Further interview revealed CNA #1 was sent home after the nurse notified the nurse on-call.</p> <p>d. Interview with CNA #1 on 1/23/26 at 8:50 AM revealed on the day of the incident, CNA #2 came and got her to assist with care for resident #3. CNA #1 revealed when she the other CNA had assisted the resident into the bathroom and the CNA did not get his/her pants and brief pulled up all the way, so upon entry to the room, there was feces, urine, and blood all over. CNA #1 revealed she moved the chair to face the wall to attempt to assist the resident with getting his her brief and pants down while CNA #2 went to get cleaning supplies. CNA #1 revealed she attempted to push the shower chair into the shower and resident #3 began to yell. CNA #1 revealed she placed her hand on the resident's shoulder to explain and the resident told her people don't listen to him/her. CNA #1 revealed she assisted the resident to remove his/her shirt and "accidentally sprayed cold water on [him/her]." CNA #1 revealed she began to wash the resident and s/he asked her to stop, which the CNA did. CNA #1 revealed the</p>	F0600	<p><b>Identifying Risk</b>                      All other residents were interviewed to assess for any further abuse incidents. Interviews indicated that no further abuse has occurred. The facility's policy on Abuse and Neglect will be re-emphasized to all residents and their representatives. <b>Completion Date 3/20/2026</b></p> <p><b>Systemic Changes &amp; Prevention</b></p> <ol style="list-style-type: none"> <li>1. Staff Training: A review of all current employee files was conducted to ensure initial abuse prevention training was completed and verified for all current staff. Additional 1:1 in-service education was conducted for all facility staff on the Abuse Policy and Procedure (Issued 12/4/23), including zero tolerance for verbal and physical abuse, proper communication techniques, and mandatory reporting obligations. A competency quiz was administered to verify understanding. <b>Completion Date 2/20/2026</b></li> <li>2. Bystander Intervention: Specific training will be provided to all staff on the expected protocol for staff who witness abuse, including the expectation to immediately ask the perpetrator to leave the room, ensure the resident is safe, and report the incident immediately, as per the Director of Nursing's expectation. <b>Completion Date 2/20/2026</b></li> </ol>	

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F0600 SS = G	<p>Continued from page 3 resident asked to see the washcloth and she showed him/her. CNA #1 revealed after she got the resident cleaned up, resident #3 started kicking her. CNA #1 revealed she did tell the resident they "needed to get the shit off [him/her]." CNA #1 revealed when she began taking the resident out of the bathroom, the nurse entered and told her to stop talking to the resident, which she did. The CNA revealed she attempted to apologize to the resident and s/he wouldn't listen. After she left the room, CNA #2 would not let her tell the nurse anything and she was told to leave the facility, which she did; however, before she left CNA #2 came out and told her if the CNA or nurse got into trouble over her or her lying, they were going to be upset with her. CNA #1 revealed she was taken off the schedule for weekend and on Sunday, her recruiter called and reported she was not allowed to return to the facility. CNA #1 revealed she did tell the resident #3 if s/he "was going to be an ass," the CNA could "be an ass" and she "needed to clean the shit off him/her."</p> <p>e. Attempts to call the RN during the survey were unsuccessful.</p> <p>2. Interview with the DON on 1/23/26 at 9:24 AM revealed she felt the incident was a concern. She revealed she expected staff who witness abuse to ask the perpetrator to leave the room, ensure the resident was safe, and report the incident immediately. Further interview revealed the facility did not implement a formal plan of correction as a result of the incident.</p> <p>3. Review of the facility policy titled "Abuse Policy and Procedure" Issued on 12/4/23 showed "...It is the policy of (Community) that each veteran will be free from 'Abuse'. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of veteran property and exploitation, corporal punishment or involuntary seclusion... Additionally, veterans will be protected from abuse, neglect, and harm while they are residing at the community. No abuse or harm of any type will be tolerated, and veterans and staff will be monitored for Protection... C. Prevention... Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of veteran property is more likely to occur..."</p>	F0600	<p><b>Monitoring</b></p> <ol style="list-style-type: none"> <li>1. The Director of Nursing (DON) and/ or a designee will conduct random, unannounced interviews with residents and staff on a weekly basis for four weeks, then monthly for three months, to ensure ongoing protection and that no further incidents of abuse occur. Results of these interviews will be documented and reviewed by the Quality Assurance Committee. Should any issues be found during the review at the QA meeting adjustments to the plan will b made and implemented. <b>Completion date 4/29/2026 .</b></li> <li>2. Incident Review: All facility incident reports related to resident-to-staff or staff-to-resident altercations will be reviewed by the DON within 24 hours to ensure appropriate, immediate action is taken and to identify any patterns or need for further intervention.</li> </ol> <p>The facility acknowledges the resident's right to be treated with respect and dignity and affirms its commitment to safe medication practices. Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed psychotropic medications were limited to 14 days for 1 of 6 sample residents (#6) reviewed for unnecessary medications. Following a thorough investigation of the incident, the facility has developed a comprehensive plan of correction designed to assess for additional systemic issues and prevent future occurrences.</p>	2/20/2026
F0605 SS = D	<p>Right to be Free from Chemical Restraints</p> <p>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)</p> <p>§483.10(e) Respect and Dignity.</p> <p>The resident has a right to be treated with respect and</p>	F0605		

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F0605 SS = D	Continued from page 4 dignity, including:  §483.10(e)(1) The right to be free from any . . . chemical restraints  imposed for purposes of discipline or convenience, and not required to treat the  resident's medical symptoms, consistent with §483.12(a)(2).  §483.12  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)(2) Ensure that the resident is free from . . . chemical restraints  imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.  ....  §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (i) Anti-psychotic;  (ii) Anti-depressant;  (iii) Anti-anxiety; and  (iv) Hypnotic.	F0605	<b>Immediate Action</b> The physician was contacted immediately to obtain a written rationale for the extended use of Ativan PRN and to establish a stop date, in accordance with regulatory requirements.  <b>Identifying Risk</b> 1. A facility-wide audit of all active PRN psychotropic medication orders was completed to identify any orders without a 14-day limit or a documented physician rationale for extended use. No additional residents were identified with PRN psychotropic without stops dates.  2. For any resident identified in the on-going weekly audits, the physician will contacted to obtain a written rationale or a stop date.  <b>Systemic Changes &amp; Prevention</b> 1. Process Implementation: A mandatory "PRN Psychotropic Medication Audit Log" will be implemented. This log will track the start date, 14-day mark, physician rationale/stop date request, and follow-up completion for all new PRN psychotropic orders. Audits will be weekly for the first 4 weeks then monthly there after. <b>Completion date for weekly 3/20/2026,</b> <b>Completion date for monthly 3/20/2027</b>  2. Staff Education: All licensed nursing staff and the DON will be re-educated on the facility policy and regulatory requirements for PRN psychotropic medication use (14-day limit/physician rationale), and the mandatory follow-up process for pharmacist recommendations <b>Completion Date 2/20/26</b>	

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F0605 SS = D	<p>Continued from page 5</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate Indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are</p>	F0605	<p><b>Monitoring</b></p> <ol style="list-style-type: none"> <li>1. he DON will audit the binder containing monthly medication reviews every month to ensure follow-up is completed for all recommendations.</li> <li>2. In addition the DON will conduct weekly audits of the PRN status of any psychotropic medications <b>Completion Date 3/20/2027 The audits will then transition to monthly for 1 year.</b></li> <li>3. The Risk Management team is responsible for reviewing weekly audits conducted by the Director of Nursing (DON) or their designee. This review ensures compliance with the 14-day limit for chemical restraints and verifies the appropriate documentation of the rationale and stop dates. <b>Completion date 3/20/2026</b></li> <li>4. Additionally, the Quality Assurance (QA) Committee will review the "PRN Psychotropic Medication Audit Log" as part of their quarterly meetings. Should issues be noted during review of the audits the QA team will adjust the plan and implement changes as needed. <b>Completion Date April 2027</b></li> </ol>	

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F0605 SS = D	<p>Continued from page 6 limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed psychotropic medications were limited to 14 days for 1 of 6 sample residents (#6) reviewed for unnecessary medications.</p> <p>1. Review of the quarterly MDS assessment dated 11/7/25 showed resident #6 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included anxiety disorder, insomnia, chronic pain, muscle weakness, and a history of cerebrovascular accident or transient ischemic attack. The following concerns were identified:</p> <p>a. Review of the physician orders dated 12/8/25 showed the resident received Ativan 0.5 milligrams (mg) every six hours as needed for anxiety. There was no evidence a stop date was indicated.</p> <p>b. Review of a monthly medication review dated 12/29/25 showed the pharmacist recommended non-antipsychotic, psychotropic medications be limited to 14 days. Further review showed the physician declined the pharmacist recommendation and deferred to mental health to address.</p> <p>c. Review of the medical record showed no evidence a physician rationale for extended use or a stop date was provided.</p> <p>d. Interview with the DON on 1/23/26 at 8:30 AM revealed that staff were expected to follow up on the monthly medication review orders that were placed in a binder at the nursing station. The DON revealed no additional follow-up for the pharmacist's recommendation was completed or followed up on by mental health services.</p> <p>2. Review of the facility policy titled "Medication Regimen Review", last revised 8/17/2023, showed "...8. Facility should encourage physician/prescriber or other responsible parties receiving monthly regimen reviews and the director of nursing to act upon the recommendations contained in the monthly regimen reviews..."</p>	F0605		
F0628 SS = D	Discharge Process	F0628		

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F0628 SS = D	<p>Continued from page 7</p> <p>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>§483.15(c)(3) Notice before transfer.</p> <p>Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in</p>	F0628	<p>The facility acknowledges its failure to issue the required 30-day formal notice prior to the resident's discharge. Recognizing a deficiency in discharge planning, the facility has assessed the situation and developed a systematic plan to address and prevent future occurrences of this issue.</p> <p><b>Immediate Action</b> Since Resident #24, the resident affected by the deficient practice, has already been discharged, no further resident-specific corrective action can be completed for this resident. The systemic plan of correction outlined in the following sections will ensure this deficient practice does not recur for any resident.</p> <p><b>Identifying risks</b> The facility has implemented systemic measures to ensure organized discharge planning is completed for all residents prior to discharge, thereby addressing the potential for any resident to be affected by the deficient practice in the future. The systemic measures, serve as the primary corrective action for all other residents. It was determined that there were two residents with potential upcoming discharges.</p>	2/19/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>535061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>01/23/2026</b>
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NAME OF PROVIDER OR SUPPLIER <b>Wyoming Veterans' Skilled Nursing Facility</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 Veteran's Lane , Buffalo, Wyoming, 82834</b>
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(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
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F0628 SS = D	<p>Continued from page 8 paragraph (c)(5) of this section.</p> <p><b>§483.15(c)(4) Timing of the notice.</b></p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p><b>§483.15(c)(5) Contents of the notice.</b> The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone</p>	F0628	<p><b>Systemic Changes &amp; Prevention</b> The facility has implemented the following measures to ensure organized discharge planning is completed for all residents prior to discharge:</p> <p><b>Establishment of a Discharge Planning Protocol:</b> A revised, step-by-step discharge planning assessment has been developed. This protocol mandates the initiation of discharge planning upon admission and a mandatory IDT meeting to finalize the plan at least 72 hours prior to the anticipated discharge date. <b>Completion Date: 2/10/2026</b></p> <p><b>Mandatory Discharge Planning Assessment Form:</b> A new, centralized discharge planning checklist/form has been created and implemented. This form must be completed and signed by all required IDT members and will remain part of the resident's records. For the residents identified as potential discharges the new assessment was implemented. <b>Completion Date: 2/2/2026</b></p> <p><b>IDT Education and Training:</b> All members of the Interdisciplinary Team (IDT), including Social Services, Nursing, and Administrative staff, have received training on the revised "Transfer or Discharge" policy and the new Discharge Planning Protocol. <b>Completion Date: 2/13/2026</b></p>	
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F0628 SS = D	<p>Continued from page 9 number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice.</p> <p>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p>	F0628	<p><b>Monitoring</b> The effectiveness of the corrective measures will be monitored through the following quality assurance (QA) plan:</p> <p>Initial Audit of 100% of New Discharges: The Director of Nursing (DON) and Social Services will conduct an initial audit of 100% of new discharges for compliance. Completion Date: 3/2/2026</p> <p>Monthly Discharge Audit: The Social Services Manager, or Director of Nursing, will audit 100% of all closed resident records with discharges for the first month following the initial training.</p> <p>QA Review: The results of the monthly audits will be reviewed by the facility's QA at their regularly scheduled meetings. Any identified deficiencies will result in immediate re-education and modification of the QA process as necessary. The next QA review is scheduled for 4/29/2026.</p>	

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F0628 SS = D	<p>Continued from page 10</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure written discharge notice was provided to residents or resident representatives for 1 of 2 sample residents (#24) reviewed for closed records. The findings were:</p> <p>1. Review of a progress note dated 10/28/25 and 1:05 PM showed resident #24 was involuntarily discharged from the facility. Further review of the progress notes</p>	F0628		

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F0628 SS = D	Continued from page 11 showed no evidence the facility provided a written discharge notice or completed discharge planning prior to the resident's discharge.  2. Interview with the DON on 1/22/26 at 4:26 PM confirmed the facility did not issue a written discharge notice or perform discharge planning prior to the resident's discharge.  3. Review of the facility policy titled "Transfer or Discharge" dated 12/4/23 showed "...The WWSN Social Services Manager (or designee if Social Services Manager is Unavailable) will provide the veteran and family member or legal representative, and the Office of the State Long-Term Care Ombudsman, with a notice of Transfer or Discharge. Notice of Community-initiate transfer or discharge will be provided 30 days before transfer or discharge unless in case of emergency transfer..."	F0628		
F0645 SS = D	PASARR Screening for MD & ID  CFR(s): 483.20(k)(1)-(3)  §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.  §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:  (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,  (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and  (B) If the individual requires such level of services, whether the individual requires specialized services; or  (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-  (A) That, because of the physical and mental condition of the individual, the individual requires the level of	F0645	The facility acknowledges and affirms the requirement for timely and complete Preadmission Screening and Resident Review (PASRR) for all residents. Following a review of the identified deficiencies related to PASRR non-compliance, the facility has developed a comprehensive plan of correction designed to address the issues and prevent future occurrences.  <u>Immediate action</u> 1. Resident #12 Immediate completion of a full PASRR process (Level I & II, if required). Results reviewed by Interdisciplinary Team (IDT).  2. Resident #4 Social services completed new PASRR I however Resident #4 was placed on end of life comfort care and Passed away on 1/29/2026, before Level II could be completed.  3. Resident # 23 Immediate completion of a PASRR Level II assessment due to Level I screening indicating mental illness but lacking Level II documentation.	2/24/26 all PASRR I will be complete and all PASRR II indicated assessment will be scheduled for completion

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F0645 SS = D	<p>Continued from page 12 services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level I or PASRR Level II was completed for 3 of 3 sample residents (#4, #12, #23) reviewed for</p>	F0645	<p><b>Identifying Risk</b> A facility-wide log has been implemented to track the PASRR completion status for all new admissions. The recent audit revealed deficiencies: one resident was missing a PASRR Level I, and three residents lacked the required PASRR Level II assessment. These four outstanding assessments will be completed immediately in addition to the assessment found during the survey and subsequently reviewed by the Interdisciplinary Team (IDT). <b>Completion Date 2/2/2026</b></p> <p><b>Systemic Changes &amp; Prevention</b></p> <ol style="list-style-type: none"> <li>1. PASRR System Access Resolution- DON and Administrator to confirm all necessary staff have active, functional access to the PASRR system. <b>Completion Date 1/26/2026</b></li> <li>2. Retraining on PASRR Process and Purpose-All staff involved in admissions/MDS retrained on PASRR purpose and process, focusing on Level I/II criteria and timely completion. <b>Completion Date 2/19/2026</b></li> <li>3. IDT Review of PASRR Findings- IDT to implement ongoing practice of reviewing all completed Level II assessments immediately to ensure appropriate care planning. <b>Completion Date 2/19/2026</b></li> </ol>	

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F0645 SS = D	<p>Continued from page 13 pre-admission screening. The findings were:</p> <p>1. Review of the quarterly MDS assessment dated 1/15/26 showed resident #12 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment, and had diagnoses which included depression and schizophrenia. The following concerns were identified:</p> <p>a. Review of the medical record showed no evidence a PASRR had been completed prior to or following the resident's admission in July 2025.</p> <p>b. Interview with the DON on 1/23/26 at 8:41 AM confirmed that a PASRR was not completed prior to or following the resident's admission.</p> <p>2. Review of a PASRR Level I dated 9/18/25 showed resident #4 had diagnoses which included schizoaffective disorder. Further review showed the resident was marked no for "Does this person have a major mental illness according to the three major criteria in 42CFR 483.102(b)," "Does this person have any history of Mental Illness requiring treatment more intensive than outpatient services in the past two years," and "Is there any presenting evidence of Mental Illness including possible disturbance in orientation, affect or mood that is not attributable to dementia or other medical diagnosis list above." Further review showed the "PASRR Level I Screening Summary" indicated the "decision" was "no evidence of mental illness or intellectual disability." Review of a "PASRR Level II Informed Consent Form" dated 10/14/25 showed the resident consented to the completion of a PASRR Level II assessment. Review of the resident's medical record showed no evidence a PASRR Level II was completed.</p> <p>3. Review of a PASRR Level I dated 11/6/25 showed resident #23 had diagnoses which included post-traumatic stress disorder and schizophrenia. Further review showed the "PASRR Level I Screening Summary" indicated the "decision" was "evidence of mental illness" and a PASRR Level II was required. Review of the resident's medical record showed no evidence a PASRR Level II was complete.</p> <p>4. Interview with the DON on 1/22/26 at 2:09 PM confirmed a PASRR Level II should have been completed for resident #4 and resident #23; however, she revealed the staff member responsible for the completion of the assessment was locked out of the PASRR system.</p> <p>5. Review of the policy titled "Preadmission Screening and Annual Veteran Review (PASARR)" dated 1/1/23 showed</p>	F0645	<p><b>Monitoring</b></p> <p>1. Weekly Compliance Audits- DON to audit 100% of new admissions and current residents with a positive Level I for timely Level II completion and follow-up. <b>Completion Date on going</b></p> <p>2. Tracking Log Review- The facility-wide tracking log will undergo a weekly review during Risk Management meetings and a quarterly assessment during Quality Assurance (QA). The quarterly QA assessment will specifically focus on evaluating the process's effectiveness and implementing necessary changes. <b>Completion Date on going</b></p>	

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F0645 SS = D	Continued from page 14 "...The community will not admit any new Veterans with: Mental Disorder-unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission or Intellectual Disability unless the State intellectual disability or developmental disability authority has determined prior to admission that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing community, and if the individual requires such level of services, whether the individual requires specialized services for intellectual disability..."	F0645		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756	The facility acknowledges the deficiency in drug regimen review procedures as cited in the survey. The facility has thoroughly reviewed the cited irregularity, conducted an appropriate investigation to identify the scope and root cause, and has implemented a comprehensive Plan of Correction to ensure the deficiency is fully corrected and does not recur.  <b>Immediate action</b> The physician's order to discontinue Hydroxyzine 25 mg PRN for anxiety for Resident #18 was immediately implemented. <b>Completion Date: Immediate 1/23/2026</b>  <b>Identify risk</b> All residents who receive medications are at risk. A comprehensive audit of all pharmacy recommendations and corresponding physician orders from the January 2025 and January 2026 Monthly Medication Regimen Reviews (Medication Review Regimens) was conducted to identify any other missed actions (2 additional noted from same month and immediately corrected). <b>Completion Date of Initial Audit was immediately conducted.</b>	2/20/2026

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F0756 SS = D	Continued from page 15  §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.  This REQUIREMENT is NOT MET as evidenced by:  Based on medical record review, staff interview, and policy and procedure review, the facility failed to act on pharmacy recommendations for 1 of 6 sample residents (#18) reviewed for unnecessary medications. The findings were:  1. Review of a monthly medication regimen review for December 2025 showed the pharmacy recommended discontinuing hydroxyzine 25 mg, taken as needed for anxiety. Further review showed the physician accepted the pharmacy recommendation and ordered hydroxyzine to be discontinued. Review of the physician orders showed the hydroxyzine had not been discontinued.  2. Interview with the DON on 1/23/26 at 8:30 AM confirmed the medication had not been discontinued.  3. Review of the facility policy titled, "Interim Medication Regimen Review," last updated 2018, showed the physician/prescriber should "...6.1. Accept and act upon the recommendations contained within the monthly medication review..."	F0756	<b><u>Systemic Changes and Prevention</u></b>  1. Tracking Log Implementation: Implemented a mandatory "Medication Review Regimen Action Tracking Log."  2. Review: DON or designee will review the Tracking Log during risk management to ensure orders are implemented the Date of the signed order.  3. Staff Education: Re-education for all licensed nursing staff, the new tracking log, and the urgency of immediately implementing physician orders. <b>Completion date 2/20/2026</b>  <b><u>Monitoring</u></b> 1. Audit of Medication Review Regimen and timely implementation of physician orders will be audited Weekly for 4 weeks, then Monthly there after by the DON/Designee. <b>Completion Date 3/20/2026 for weekly. Completion Date 4/29/2026 for monthly</b>  2. Physician Documentation will be reviewed documentation for medication change Monthly with the medication review binder by the Medical Director/DON. <b>Completion Date 4/29/2026</b>  3. Audits will be of the weekly risk management to ensure the Tracking Log is reviewed, Weekly for <b>4 weeks by the Director of nursing. Completion date 3/20/2026.</b>  4. Results the audits will be reported to the facility's QA Committee, which will determine when the deficient practice has been fully corrected or changes to the plan need implemented. <b>Completion Date 4/29/2026</b>  The facility failed to ensure the multi-dose insulin pen was properly labeled, and acknowledges the significant risk this error poses for residents due to the potential for medication error. The facility has developed and implemented the following Plan of Correction to address this deficiency and prevent recurrence:	
F0761 SS = D	Label/Store Drugs and Biologicals  CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have	F0761		2/20/2026

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F0761 SS = D	<p>Continued from page 16 access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to label and provide the date medications were opened in 1 of 2 two cottages (Cottonwood). The findings were:</p> <ol style="list-style-type: none"> <li>1. Observation on 1/22/26 at 8:24 AM showed an Insulin Glargine 100 unit/1 milliliter (ML) pen which was opened, partially used, and not dated.</li> <li>2. Interview with RN #1 on 1/22/26 at 8:24 AM revealed the insulin pen had been used and confirmed insulin pens should have been labeled with the opened date.</li> <li>3. Interview with the DON on 1/23/26 at 10:12 AM confirmed staff were expected to label multi-dose insulin with the date it was opened.</li> <li>4. Review of the facility policy titled "Multidose Vial Use" dated August 2024 showed, "...A.1. All multi-dose vials are dated with a 28-day expiration date, as the last date that a product is to be used...A.2. All multi dose vials are labeled with the expiration date at the time of original opening by the person initially accessing the multi-dose vial..."</li> <li>5. Review of the insulin manufacturer recommendations titled "Highlights of Prescribing Information" last revised 2025 showed "...Only use your pen for up to 28 days after it's first use..."</li> </ol>	F0761	<p><b>Immediate Action</b> The partially used and unlabeled Insulin Glargine 100 unit/1 milliliter (ML) pen was immediately removed from use and discarded on 1/22/26. All other medication cabinets and carts were inspected, and any instances of missed labeling were immediately corrected. <b>Date of completion 1/23/2026.</b></p> <p><b>Identifying Risk</b> The potential risk extends to all residents.</p> <p><b>Systemic Change &amp; Prevention</b> Re-Education/Training: All licensed nursing staff and medication administration staff will receive immediate in-person 1:1 training on the proper policy and procedure for handling, labeling, and storing all multi-dose medications, including insulin pens. This training will emphasize the requirement to date the medication with the "open" date and/or the 28-day beyond-use date upon initial access. The training session will be held on Date. <b>Completion Date 2/20/2026</b></p> <p>Visual Reminders: Medication storage areas will be equipped with visual reminders (e.g., laminated signs, stickers) near multi-dose medications, specifically reminding staff to "Date upon Opening". <b>Completion Date 2/20/2026</b></p> <p><b>Monitoring</b> The Director of Nursing (DON) or their designee (e.g., Nurse Manager) will implement a focused audit program to ensure sustained compliance with multi-dose medication labeling requirements. Audit Measures: Random audits of multi-dose medication in medication carts and rooms (checking for open date/expiration) will be conducted weekly for 4 weeks, then Monthly. Audit Review Process: The facility will conduct weekly audits for 4 weeks. These weekly audits will be reviewed at the weekly Risk Management meeting. Thereafter, the monthly audits will be reviewed at the Quality Assurance (QA) meeting. If issues or negative trends are identified, the Performance Improvement plan will be revised and re-implemented. <b>Completion Date 4/29/2026</b></p>	
F0812 SS = F	<p>Food Procurement, Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p>	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>535061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>01/23/2026</b>
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F0812 SS = F	<p>Continued from page 17</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, staff interview, policy and procedure review, and food code review, the facility failed to ensure food was stored in accordance with professional standards for food service safety. The census was 24. The findings were:</p> <p>1. Observation of the warehouse walk-in freezer on 1/22/26 at 10:12 AM showed a black plastic bag was positioned near the entry door, on the floor. Interview with the dietary manager at that time, revealed the bag contained a cow hide, which was his personal item, and he was planning to remove it that day. The manager stated the hide had not been in the freezer long and he confirmed the other items in the freezer were for resident consumption. Observation on 1/22/26 at 11:14 AM showed the dietary manager tore open the black plastic bag which revealed what appeared to be a cow hide, with black hair, folded onto itself in a square. The hide was visibly frozen with ice accumulation on the flesh and hair.</p> <p>2. Interview with the facility administrator on 1/22/26 at 11:21 AM revealed he was aware the hide had previously been in the freezer and he thought it had been removed. The administrator revealed he heard about the hide over the summer and had asked the dietary manager to take it out, which he thought had occurred. He revealed it was unsure if the hide had been removed and returned to the walk-in freezer. Further interview confirmed the hide should not have been stored in the walk-in freezer.</p>	F0812	<p>The facility acknowledges the deficiency could potentially negatively impact all Skilled Nursing Residents. Following immediate removal of the cowhide, the facility has developed a comprehensive plan of correction designed to ensure cleanliness, safety, and organization of the Veterans' Home of Wyoming warehouse.</p> <p><b>Immediate Action</b> On 1/22/2026 at approximately 10:12AM a cowhide was discovered in the deep freeze of the warehouse walk-in freezer. After speaking with the Survey team, the Dietary Manager immediately removed the cowhide from the freezer. Furthermore, The cowhide was removed from the premises later on the same day. Staff meetings were utilized to educate managers on the importance of warehouse sanitation and organization. <b>Completion Date 1/22/2026</b></p> <p><b>Systemic Changes &amp; Prevention</b> Immediate Audits took place of the warehouse and deep freeze to ensure proper safety, organization, and cleanliness. The Maintenance Supervisor conducted weekly audits for a time period of one month. Audits for cleanliness, organization, and safety were performed on: 1/27/2026 - 2/3/2026 - 2/10/2026 - 2/17/2026 <b>Completion date 2/17/2026</b></p> <p><b>Monitoring</b> The facility will ensure future compliance through ongoing Audits for cleanliness, organization and safety. Maintenance Supervisor will continue with Random Monthly Audits until the next Quality Assurance meeting. QAPI meeting schedule for 4/29/2026.</p>	2/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026
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F0812 SS = F	Continued from page 18  3. Review of the policy titled "Food Prep and Storage" dated 12/4/23 showed "...9.Protect food from contamination or cross-contamination during preparation, services and storage through precautionary measures in accordance with current food code guide, including use of clean, properly sanitized equipment; optimum refrigerator temperatures; proper handling of food by healthy personnel who wash hands thoroughly after touching any food or objects that may be contaminated; and storage and use of poisonous or toxic materials away from the food..."  4. Review of the 2022 Food Code, US Food and Drug Administration, showed "...3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor..."	F0812		
F0851 SS = F	Payroll Based Journal  CFR(s): 483.70(p)(1)-(5)  §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.  Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.  §483.70(p)(1) Direct Care Staff.  Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).  §483.70(p)(2) Submission requirements.  The facility must electronically submit to CMS complete and accurate direct care staffing information,	F0851	The facility acknowledges and affirms the requirement for mandatory submission of staffing information via the Payroll-Based Journal (PBJ) system. Following a review of the identified deficiencies related to the failure to submit data for Fiscal Year 2025 Quarters 2, 3, and 4, the facility has developed a comprehensive plan of correction designed to address the issues and prevent future occurrences.  <b>Immediate Action</b> The facility has establish the director of nursing as a backup for Human Resources (HR) and the DON will gather and upload all Payroll-Based Journal (PBJ) data for all upcoming quarters when HR is unavailable <b>Completion date: 2/20/2026</b>	2/20/2026

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F0851 SS = F	<p>Continued from page 19 including the following:</p> <p>(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);</p> <p>(ii) Resident census data; and</p> <p>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).</p> <p>§483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.</p> <p>§483.70(p)(4) Data format.</p> <p>The facility must submit direct care staffing information in the uniform format specified by CMS.</p> <p>§483.70(p)(5) Submission schedule.</p> <p>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on payroll based journal staffing report review, and staff interview, the facility failed to ensure mandatory submission of staffing data. The census was 24. The findings were:</p> <p>1. Review of the fiscal year 2025 quarter 2 (January 1-March 31) payroll based journal staffing report showed the facility triggered for the metric "Failed to Submit Data for the Quarter."</p> <p>2. Review of the fiscal year 2025 quarter 3 (April 1-June 30) payroll based journal staffing report showed the facility triggered for the metric "Failed to Submit Data for the Quarter."</p>	F0851	<p><b>Identifying Risk</b> All residents are at risk with lack of PBJ reporting. Potential for compromised quality of care and resident safety due to inaccurate or absent public reporting of staffing levels.</p> <p><b>Systemic Change &amp; Prevention</b> Due to the current vacancy in the HR position, the Director of Nursing will assume responsibility for the Payroll-Based Journal (PBJ) system. The Director of Nursing will obtain access to the PBJ system and serve as a backup until a new HR individual is hired. <b>Completion date 2/20/2026</b></p> <p>Mandatory schedule implemented, requiring submission and validation by the 40th day after the end of each fiscal quarter (5-day buffer before CMS deadline). <b>Completion date 2/20/2026</b></p> <p>All PBJ submission deadlines entered into the facility's master compliance calendar with automated reminders scheduled two weeks prior to the deadline. <b>Completion date 2/20/2026</b></p> <p><b>Monitoring</b> To ensure compliance with Payroll-Based Journal (PBJ) submission requirements, staff hours will be compiled and reviewed on a monthly basis to prepare for the quarterly submission. This monthly review will take place during one of the weekly risk management meetings. A more comprehensive review will occur quarterly during the Quality Assurance (QA) meeting. Following the data and audit reviews, any issues identified will result in adjustments to this plan, which will then be implemented to maintain compliance. <b>Completion Date: 4/26/2026</b></p>	

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

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F0851 SS = F	Continued from page 20  3. Review of the fiscal year 2025 quarter 4 (July 1-September 30) payroll based journal staffing report showed the facility triggered for the metric "Failed to Submit Data for the Quarter."  4. Interview with the DON on 1/23/26 at 8:30 AM revealed the facility was aware the payroll based journal reporting was not consistent. Further interview revealed the previous HR director had inconsistent access to the payroll based journal reporting system.	F0851		
F0883 SS = D	Influenza and Pneumococcal Immunizations  CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations  §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-  (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;  (iii) The resident or the resident's representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:  (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and  (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives	F0883	The facility acknowledges the failure to ensure the timely administration and proper documentation of the pneumococcal vaccine for all eligible residents. This Plan of Correction outlines the specific actions implemented and systemic changes to be made to ensure that the deficient practice will not recur. It is submitted as our credible allegation of compliance.  <b>Immediate Action</b> Affected Resident #12 was immediately assessed and administered the appropriate pneumococcal vaccine (Prevnar 20). The medical record was updated to reflect the vaccine administration and confirmed documentation of the signed consent dated 7/9/25. <b>Completion Date 2/3/2026</b>  <b>Identifying Risk</b> A comprehensive audit of all current residents' medical records was conducted to determine immunization status and documentation. The audit included assessment for eligibility, confirmation of consent/refusal, verification of administration (within 30 days of admission or as indicated), and review of planned future doses. <b>Completion Date 2/3/26</b>	2/3/2026

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F0883 SS = D	<p>Continued from page 21 education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on medical record review, staff interview, and policy and procedure review the facility failed to ensure the residents were immunized for pneumococcal disease in 1 of 5 sample residents (#12) reviewed for current vaccination status. The findings were:</p> <p>1. Review of medical record for resident #12 showed his/her most recent Pneumococcal Conjugate Vaccine (PCV13) was administered on 10/18/19, and the facility planned to administer Prevnar 20 at the time of admission in July 2025; however, there was no record the resident received the vaccine. Review of the resident vaccine consent form dated 7/9/25 showed the resident had consented to receive the pneumonia vaccine.</p> <p>2. Interview with the Infection Preventionist on 1/23/26 at 10 AM confirmed the resident did not receive the vaccine.</p> <p>3. Review of the facility document titled "Wyoming Veterans' Skilled Nursing Policies and Procedures," dated 12/2023 showed "...1. Prior to or upon admission, Veterans will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the community unless contraindicated...7. Administration of the pneumococcal vaccines or</p>	F0883	<p><b>Systemic Changes &amp; prevention</b></p> <ol style="list-style-type: none"> <li>1. Admission Process Check-Off: with all admissions IP Nurse to verify immunizations are administered, scheduled, or documented as refused/contraindicated.</li> <li>2. Vaccine Tracking System Improvement: A centralized, audit-able log will be implemented to document the order date, consent date, and administration date. The IP will check this log weekly. <b>Completion Date will remain on going.</b></li> <li>3. Infection Preventionist Oversight: The IP will be responsible for a weekly review of all new admissions for compliance. IDT team will verify compliance with first quarterly care conference after admission. <b>Completion Date will remain on going permit process change.</b></li> </ol> <p><b>Monitoring</b></p> <ol style="list-style-type: none"> <li>1. An audit system was established to assess all new admissions for appropriate immunization status at the first quarterly care conference.</li> <li>2. A tracking sheet was established to maintain current immunization status. The tracking sheet will be reviewed at one of the weekly risk management meetings each month.</li> <li>3. All audits will be reviewed at the quarterly QA meeting. If any issues are discovered, the plan will be reviewed and changes implemented. <b>Completion Date 4/29/2026</b></li> </ol>	

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

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F0883 SS = D	<p>Continued from page 22 revaccinations will be made in accordance with the current Centers for Disease Control and Prevention recommendations at the time of the vaccination..."</p> <p>4. Review of the Centers for Disease Control "Vaccines and Administration Schedule", last revised 2025 showed "...Adults over 50 years of age who previously received one dose of PCV13 should receive one dose of PCV20 or one dose of PCV21 at least 1 year after the last PCV13 dose..."</p>	F0883		
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