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

REVISED PER CMS REQUEST - 6.01.2026
(Revisions in Red)

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 04/24/2026

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 4/22/26 through 4/24/26. The survey was prompted by complaint intakes 2965047, 2962496, 2689334, 2679325, 2650747, 2641109, 2572080, 2635333, 1900728, 1900725, 2588577, and 1900719. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F0000		
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;	F0600	F-600 **Free From Abuse and Neglect** **CFR(s): 483.12(a)(1)** This STANDARD is not met as evidenced by: Based on observation, staff interview, record review, facility investigation review, and policy review, the facility failed to protect the residents' rights to be free from verbal abuse, physical abuse, and sexual abuse by staff and residents for 3 of 8 sample residents (#4, #12, #16) reviewed for allegations of abuse and neglect. This failure resulted in actual harm to resident #16. **Corrective Action(s):** **1 a-d) 2 a-b) 3 a-e)** 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 individual and group activities. Social Services will conduct weekly safety interviews for 1 month, then bi-weekly for another month, and once a month for a final month. • Staff to follow the protection from harm policy/protocol/ standard operating procedure. • Staff to remove the resident if housemates are experiencing altered behavioral symptoms to ensure safety and psychosocial support	6/01/2026

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
Kerry George	Facility Administrator	6/01/2026

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F0600 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, facility investigation review, and policy review, the facility failed to protect the residents' right to be free from verbal abuse, physical abuse, and sexual abuse by staff and residents for 3 of 8 sample residents (#4,#12,#16) reviewed for allegations of abuse and neglect. This failure resulted in actual harm to resident #16. The findings were: 1.Review of the quarterly MDS assessment dated 3/3/26 showed resident #4 had a BIMS score of 15 out of 15, which indicated normal cognitive function and diagnoses of non-traumatic brain dysfunction, anxiety and schizophrenia. Review of the quarterly MDS assessment dated 2/25/26 showed resident #16 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment, and diagnoses which included traumatic brain dysfunction, anxiety and depression. The following concerns were identified: a. Review of the facility incident report dated 3/17/26 showed there had been an incident in the kitchen area between resident #16 and #4 where unknown words were exchanged and resident #4 struck resident #16 in the forehead with a cup. When the staff intervened, resident #4 slipped and fell on the water from the cup. Both residents were separated, removed from the area, and assessed. b. Interview with RN #5 on 4/24/26 at 1:15 PM revealed she left the medication room after she heard a commotion, and saw resident #4 on the ground. She revealed the staff tried to help him/her off the floor and s/he fell again. She revealed when he assessed resident #4 and s/he had a bruise on his/her back and when she assessed resident #16, she found a half circle mark on his/her forehead which looked like the bottom of the cup s/he had been hit with. c. Interview with facility investigator #1 on 4/24/26 at 11:27AM revealed resident #16 had been verbally abusive to staff and continued to mumble negative things when resident #4 retaliated by hitting her/him with the cup. d. Review of a progress noted dated 3/18/26 showed "follow up on Head Injury. Assessment first thing this morning. [Resident #16] is awake and alert in [his/her] room. [S/he] reports [s/he] was able to sleep pretty good. Alert to person, place, time and event. Crescent shaped pink area noted to [his/her] left forehead. It does not seem to be tender when I	F0600	F-600 (Continued) Free From Abuse and Neglect CFR(s): 483.12(a)(1) • Staff to monitor for increased agitation and be proactive in offering support prior to a behavior. • Staff to remain in the main areas of the home when residents are awake and out of their rooms. • Staff to be in-serviced on updated care plans as they are changed. All new staff are to be trained on care plans prior to working the floor. All staff to be signed off by 6/01/26. • IDT will review care plans monthly for 3 months or as needed to meet residents' needs. • Staff to update the RST on care plan changes, and lock the assessment so CNAs can see all changes to care plans. • Staff to be in-serviced on a safe, calm environment. • Review interventions after each incident, to include monitoring interventions on 72 charting, ABC sheets, safety interviews, review at the daily clinical meeting, and the Stand Up meetings. • Staff are to remain in the main area of the home when residents are awake. Resident #4 and #16 were immediately separated after the resident-to-resident altercations on 3/17/26. Staff to remain in the main areas of the home when residents are awake and out of their rooms. Staff to remain out of the report room and be present in the main areas of the cottage when applicable. Resident #4 was assessed by the team for behavioral symptoms; the care plan was updated to include interventions. Staff to acknowledge the emotions, open-ended questions, active listening, and provide positive feedback. Allow him to discuss his feelings in a safe, calm environment. Provide positive feedback, active listening, and validation, and refrain from challenging his own perception. If able, attempt to reorient him to time and place. Allow him to utilize the environment of his choice, including the recreational center, the activity center, and the den of the house. Utilize off-campus counseling. Genesight Testing was provided on 4/8/26 and is being reviewed by the behavioral health team.	

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F0600 SS = G	Continued from page 2 touched the area." 2. Review of the quarterly MDS assessment dated 3/8/26 showed resident #4 had a BIMS score of 15 out of 15 which indicated normal cognitive function, and had diagnoses of non-traumatic brain disorder, anxiety and schizophrenia. Further review showed the resident had risk for "behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)" for 1 to 3 days during the look back period. Review of the care plan dated 1/10/24 indicated that all staff followed the protection from harm policy, protocol, and standard operating procedures. Review of the admission MDS assessment dated 6/15/25 showed resident #6 had a BIMS score of 4 out of 15 which indicated severe cognitive impairment, and had diagnoses which included traumatic brain injury, Parkinson's disease, psychotic disorder and post-traumatic stress disorder. The following concerns were identified: a. Review of a facility investigation dated 7/10/25 showed resident #6 was in the common area with other residents and staff when s/he stated s/he was going to ejaculate on the nurse's face and then told resident #4 s/he was going to put his/her genitals on the resident's back. Resident #6 then proceeded to expose his/her genitals, make inappropriate sexual gestures, and asked others to "touch it." Further review showed the resident urinated on the carpet, a "code green" was called, and resident #4 was removed from the area. b. Interview with RN #7 on 4/23/26 at 2:10 PM revealed resident #6 demonstrated many threatening behaviors she tried to redirect which worked until the resident exposed themselves, made inappropriate sexual gestures, and urinated on the floor, which triggered her to call the "code green." Further interview revealed resident #4 had been upset after the interaction and had to be redirected. 3. Review of the quarterly MDS assessment dated 3/3/26 showed resident #4 had a BIMS score of 15 out of 15, which indicated normal cognitive function, and diagnoses of non-traumatic brain dysfunction, anxiety and schizophrenia. Review of the quarterly MDS assessment dated 1/21/26 showed resident #12 had a BIMS of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses of intracranial injury, neurogenic bladder, incontinence of bowel and bladder, and hemiplegia. The following	F0600	F-600 (Continued) **Free From Abuse and Neglect** **CFR(s): 483.12(a)(1)** Resident #16 was assessed by the team for behavioral symptoms; the care plan was updated to include interventions. Staff to acknowledge the emotions, open-ended questions, active listening, and provide positive feedback. Allow him to discuss his feelings in a safe, calm environment. Provide positive feedback, active listening, and validation, and refrain from challenging his own perception. If able, attempt to reorient him to time and place. Reinforcement of positive behaviors, positive engagement, and replacement behaviors. Receiving services with a mental health counselor on campus, and has a behavioral team, medical, and social services support. Received Genesight Testing on 5/21/2026, and the behavioral team will review. SNF IDT will start a weekly check-in with residents to include living environment, housemate concerns, etc. Angel Rounds started and reviewed weekly at clinical meetings on 4/30/2026. Resident #6, reviewed care plan interventions, reduced stimuli, and redirected the resident. This resident was admitted to SNF on 6/9/25 due to an acute medical decline. Health began to significantly improve, and they were no longer appropriate for SNF. Medical 1:1 placed to assist residents. Increased agitation and behaviors resulted in returning to the ICF campus on 9/5/25, where it's a more of an appropriate placement. 3 a-e) • Staff to follow the protection from harm policy/protocol/ standard operating procedure. • Staff to monitor for increased agitation and be proactive in offering support prior to a behavior. • Staff to be in-serviced on updated care plans as they are changed. All new staff are to be trained on care plans prior to working the floor. All staff to be signed off by 6/01/26. • IDT will review care plans monthly for 3 months or as needed to meet residents' needs. • Staff to update the RST on care plan changes, and lock the assessment so CNAs can see all changes to care plans. • Staff to be in-serviced on a safe, calm environment.	

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F0600 SS = G	Continued from page 3 concerns were identified: a. Review of the facility investigation dated 3/20/26 showed oncoming staff found resident #12 in his/her clothes from the day before and saturated in urine and feces. The incident review showed feces was also found on the walls, floor, oxygen machine, and on the TV. The incident review showed resident #4 was reported to have been "visibly shaking and upset" that s/he had to come out of his/her room multiple times during the night to get help and a CNA from another cottage had put resident #12 to bed around 9 PM. Further review showed resident #12's life safety checks were not performed every 30 minutes, CNA #17 and CNA #19 were placed on administrative leave for investigation, and the CNAs were terminated. b. Interview with the facility investigator #1 on 4/24/26 at 11:27AM revealed when she arrived at work on the morning of the incident, she was called to the cottage of the incident where she observed resident #12 was in his/her clothes and shoes from the day before, and there was feces on the resident and all over the room. c. Interview with CNA #21 on 4/24/26 at 12:15 PM revealed he came to work at approximately 6:30 AM the day of the incident and he heard resident #12 yelling for help. When he entered the room, he found the resident had feces all over the room and him/herself, was saturated in urine, and wore clothes and shoes from the previous day. He revealed the resident had a history of digging in his/her brief and spreading his bowel movements when s/he had to sit in them for long periods of time, but he had not seen that behavior from the resident in a year of working there. He revealed he left the room and notified the guide and administrative staff of the situation, cleaned up the resident, and cleaned the room of the mess. He revealed it took him a long time to get the feces off of the resident as it was dried on and difficult to remove. Further interview revealed he was familiar with this resident and the resident did not generally wear his/her shoes and day clothes to bed. d. Interview with social services #1 on 4/24/26 at 4:17 PM revealed when she got to work the day of the incident, the CNAs and guide were frantic about the situation and she instructed them to involve investigations. She observed resident #12's room with feces on walls, bed, floor and TV. She revealed while the staff tended to resident #12, she checked on all the other residents on the unit to make sure harm had not come to anyone else.	F0600	**F-600 (Continued)** **Free From Abuse and Neglect** **CFR(s): 483.12(a)(1)** • Review interventions after each incident, to include monitoring interventions on 72 charting, ABC sheets, safety interviews, review at the daily clinical meeting, and the Stand Up meetings. • Training on the Abuse/Neglect policy prior to working in the area. • Reeducate all staff on Abuse/Neglect Policy monthly for 3 months, then quarterly. • Angel Rounds started on 4/30/26 and reviewed weekly with IDT. How the Facility Will Identify Other Residents Affected and the Measures to Be Put in Place are detailed in the plan of corrections. Monitoring and Tracking: The Social Worker will conduct weekly safety interviews for 1 month, then bi-weekly for another month, and once a month for a final month. SNF IDT will start a weekly check-in with residents to include living environment, housemate concerns, etc. The results of these interviews will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Nursing Home Administrator, Director of Nursing, and Social Worker	

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F0600 SS = G	Continued from page 4 e. Interview with RN #9 on 4/23/26 at 2 PM revealed she assessed resident #12 after the incident and he did have some redness to the sacral area but no skin break down and it resolved without issue. She revealed resident #4 had been assessed and had calmed down, and had no visible injuries. 4. 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. WLRC will not tolerate any form of resident abuse and will continually monitor facility policies, procedures, training programs, etc., to assist in preventing resident abuse..."	F0600	F-0689 **Free of Accident Hazards/Supervision/Devices** CFR(s): 483.25(d)(1)(2) This STANDARD is not met as evidenced by: Based on staff interview, medical record review, policy review, and facility incident investigation review, the facility failed to ensure adequate supervision was provided for 2 of 8 sample residents (#2, #14) reviewed for accident hazards. The failure resulted in actual harm to resident #2. **Corrective Action(s):**	
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, medical record review, policy review, and facility incident investigation review, the facility failed to ensure adequate supervision was provided for 2 of 8 sample residents (#2, #14) reviewed for accident hazards. The failure resulted in actual harm to resident #2. The findings were: 1.Review of the quarterly MDS dated 3/24/25 showed resident #2 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment, and had diagnoses of traumatic brain injury, non-Alzheimer's dementia, hemiplegia, and chronic lung disease. Review of the care plan dated 3/7/25 showed the resident had a high to severe risk of choking and aspiration due to the lack of ability to clear his/her throat with textures above puree, and required 1 to 1 supervision and close attention to swallowing during all meals. The care plan showed the resident required a pureed food texture (IDDSI Level: 4) and liquid consistency of moderately thick	F0689	1 a-d) • Staff to follow the policy on mealtimes, and education on all meal times prior to working with the residents. • Staff must be within line of sight during all meals. • No breaks during meal times for any staff. • Training on the Abuse/Neglect policy prior to working in the area. • Staff to be in-serviced on updated care plans as they are changed. All new staff are to be trained on care plans prior to working the floor. All staff to be signed off by 6/01/26. • IDT will review care plans monthly for 3 months or as needed to meet residents' needs. • Reeducate all staff on Abuse/Neglect Policy monthly for 3 months, then quarterly. • Angel Rounds started on 4/30/26 and reviewed weekly with IDT.	6/01/2026

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F0689 SS = G	Continued from page 5 to extremely thick (IDDSI Level 3-4). Further review showed the resident should not be left around food unsupervised to prevent and reduce risk of choking. The following concerns were identified: a. Review of the facility investigation dated 4/22/25 showed after resident #2 finished her/his meal, which CNA # 3 had been assigned to supervise, the resident had been left at the dining room table while other residents continued to eat. CNA #3 and CNA #7 left the dining area and went to the staff room, and CNA #5 was on a break. When CNA #3 and CNA #7 returned to the dining room they found resident #2 with a slice of pizza. The incident review showed CNA #3 removed the pizza slice from the resident's hands and mouth then left the building for a break. After the pizza was removed from the resident, CNA #5 and CNA #7 observed the resident choking on the remaining pizza and called for help. The incident review showed the nursing staff arrived and provided the resident two to three Heimlich maneuver thrusts and suctioning. Further review showed the incident caused resident #2 to have below normal oxygen levels, required increased supplemental oxygen, and was sent to the ER for evaluation. b. Interview with CNA #3 on 4/24/26 at 1:02 PM confirmed resident #2 was left at the dinner table unsupervised. The CNA revealed she believed the resident was done eating and didn't need further supervision. The CNA confirmed at the time of the incident, there was no staff present in the dining area and the resident obtained pizza from another resident which caused him/her to choke. c. Interview with CNA #7 on 4/24/26 at 2:50 PM confirmed she was with CNA #3 in the staff office after she assisted the resident with the meal, and when she returned to the dining area, resident #2 had pizza in her/his mouth. She confirmed CNA #3 went on break after she removed the pizza from the resident. She confirmed the resident choked on residual pizza after it had been removed, and additional staff responded to clear the resident's airway and send the resident for evaluation. d. Interview with the administrator on 4/24/26 at 4:17 PM revealed the expectation for residents that need supervision varied for each resident, and depended on the areas of supervision that were found in each resident's care plan. 2. Review of the significant change MDS dated 3/7/26 showed resident #14 had a BIMS score of 3 out of 15, which indicated severe cognitive	F0689	F-0689 (Continued) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) • Weekly meal time review for resident #2, review weekly for 4 weeks, monthly for 2 months, or as necessary, or any changes from Speech Language Pathologist. • Started seeing Speech Language Pathology on 7/9/25 and is still seeing them. Ongoing monitoring for any changes. 2 a-h) • Elopement Risk Assessment to be completed quarterly or as necessary. • Staff to be in-serviced on updated care plans as they are changed. All new staff are to be trained on care plans prior to working the floor. All staff to be signed off by 6/01/26. • IDT will review care plans monthly for 3 months or as needed to meet residents' needs. • Staff to update the RST on care plan changes, and lock the assessment so CNAs can see all changes to care plans. • Review interventions after each incident, to include monitoring interventions on 72 charting, ABC sheets, safety interviews, review at the daily clinical meeting, and Stand Up meetings. • Staff are to remain in the main area of the home when not providing individual care. • Ensure the Wander Guard is in working order. The Operations department will do monthly checks on the system per the manufacturer's recommendations. • If resident #14 leaves the cottage, the staff will follow her and keep her within line of sight. • Staff to be in service on the Wandering/Elopement policy. All new staff must be in-serviced prior to working on the floor. All staff to be signed off by 6/01/26. • The new MDS Coordinator will be responsible for documentation of care conference meetings and ensuring elopements/wandering are addressed at all care conferences.	

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F0689 SS = G	Continued from page 6 impairment, and had diagnoses of moderate non-Alzheimer's dementia, arthritis, osteoporosis and macular degeneration of both eyes. Review of the 11/11/25 and 8/13/25 quarterly MDS assessments indicated the resident had wandering behaviors 1 to 3 days during the look-back period and the impact of wandering had not been assessed. Review of the resident's impaired memory and risk for elopement care plan last revised on 11/18/25 showed interventions which included staff to remain vigilant to the resident's whereabouts and maintain " STOP" signage on all doors at all times, assure door alarms on outside doors and wander guard are in good working order at all times, and daily reminders for him/her to notify staff when resident is leaving. Further review showed the resident should be assessed for potential physical or emotional reasons for wandering which included depression, need for toileting, water, food or pain relief, restlessness, agitation, symptoms of anxiety, exit watching/seeking, escaping from embarrassment and attempts to find "someone in charge." The following concerns were identified: a. Review of a progress note dated 12/9/25 and timed 2 AM showed the resident had been up all night, went to speak with the RN in the medication room to report multiple complaints, and then left the room. At approximately 2:15 AM the back door alarm went off and the CNAs and RN found the resident had attempted to get into the door of the adjacent cottage. The resident had his/her walker with food on it and did not wear a coat. Further review showed the resident had been escorted back to his/her residence, had been assessed, and had been found not to have any injuries. b. Review of a progress note dated 4/18/26 and timed 11 PM showed the resident was believed to have left out the front door as the alarm went off. Staff went to assess the alarm to find the front door open and they were not able to see anyone. Room checks were completed and the resident was found missing. Staff then called security to help look for the resident who then found the resident at 11:10 PM in front of the education building. Further review showed the resident was escorted back to his/her residence, was assessed, and was found to have no injuries. The resident stated that s/he was looking for an administrator to talk with about his/her concerns. c. Review of the medical record showed the resident had 15 incidents of elopements between 1/19/25 and 4/18/26 which resulted in the resident being found outside his/her residence without staff knowledge.	F0689	**F-0689 (Continued)** **Free of Accident Hazards/Supervision/Devices** **CFR(s): 483.25(d)(1)(2)** How the Facility Will Identify Other Residents Affected and the Measures to Be Put in Place are detailed in the plan of corrections. Monitoring and Tracking: The Operations department will conduct monthly checks on the Wander Guard system. The Operations department has been checking the Wander Guard system on a monthly basis since February 2026. The Operations staff tests system testing, tag inspection, door and keypad functionality, and alarm notification verification. Staff complete a form with the results of testing the system. The new MDS Coordinator will be responsible for documenting care conference meetings and ensuring that elopements/wandering are addressed at all care conferences and tracked. The MDS documentation will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Nursing Home Administrator, Director of Nursing, Social Worker, MDS Coordinator, and Operations Manager.	

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F0689 SS = G	Continued from page 7 d. Interview with the facility investigator #1 on 4/24/26 at 11:20 AM revealed on 12/2/25 at 4 PM she was leaving her temporary office in the Sapphire building and found resident #14 outside on the road with a walker. The investigator revealed the resident was upset that no one would engage with him/her inside the residence. The investigator revealed she was able to get the resident into her office, where they spent approximately 20 minutes talking, and then they walked around the campus before they returned to the resident's home. She revealed the resident had been known to wait until everyone was out of the common area before s/he eloped from the residence. Further interview revealed the investigator believed there was an ongoing debate between staff about what was considered elopement. e. Review of an elopement risk assessment dated 1/28/26 revealed resident #14 attempted elopement weekly with some successful attempts with interventions in place. f. Review of the "care conference meetings" for the resident on dates 12/3/24, 2/26/25, 5/27/25, 2/4/26 and 3/6/26 showed no evidence that resident elopement had been discussed and no evidence interventions had been evaluated. g. Interview with the administrator on 4/24/26 at 4:17 PM revealed she treated any resident who left a cottage or went to the "green lines" without staff knowledge as an elopement. She revealed these designations of boundaries depended on resident specific needs and risks, that were found in individual resident care plans. Further she revealed the resident had a wander guard on his/her walker for being high risk for elopement. h. Review of facility policy titled Wandering and Elopement dated 4/2022 showed "... 3. If MDS 3.0 item E1000 A is checked "yes" an Elopement Risk Assessment will be performed and a care plan updated and revised to ensure safety... 6. A care plan identifying wandering and elopement risk will be implemented on admission with quarterly review and as needed..."	F0689	F-0684 **Quality of Care** CFR(s): 483.25 This STANDARD is not met as evidenced by: Based on staff interview, medical record review, facility investigation review, professional standard review, and policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 8 sample residents (#10) reviewed for quality of care. **Corrective Action(s):** 1 a-d) 2) 3) 4) • IDT to review the Invega Shot at clinical meetings, and complete an audit on IM injections once a month for 3 months. • Educate all nurses on the Administering and Documenting Medications Policy monthly for 3 months, and then for 2 quarters. • IDT will review care plans monthly for 3 months or as necessary to meet the needs of the residents. • IDT to review at Care Conferences with Guardians to ensure this is the best practice and interventions put into place are still effective. Done quarterly or as necessary. • CNA education on Standard Precautions to be completed by 6/01/26. • Nursing PIP for Medication Administration for the rest of 2026.	6/01/2026
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	F0684		

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 04/24/2026

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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F0684 SS = D	Continued from page 8 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 staff interview, medical record review, facility investigation review, professional standard review, and policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 8 sample residents (#10) reviewed for quality of care. The findings were: 1. Review of the quarterly MDS assessment dated 2/5/26 showed resident #10 had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment, and had diagnoses which included nontraumatic brain dysfunction, schizoaffective disorder, depression and hypertension. Review of the resident's care plan last revised on 3/19/26 showed a history of delirium, cognitive loss, depression and non-compliance with taking medications. Further review showed the resident did not believe s/he had medical issues and s/he did not need medications. The care plan showed nurses were to approach the resident calmly to inform him/her when it was time for his/her medication and if s/he refused, nursing would politely accept his/her refusal, walk away, and may attempt again later. The following concerns were identified: a. Review of a progress note dated 1/22/26 and timed 3:41 PM showed the resident received his/her monthly Invega medication and it was "administered to L [left] flank [the side of the torso between the lower rib cage and the top of the hip bone] area after transfer to w/c [wheelchair] from van. Resident did not flinch or express discomfort or change facial expression during administration." b. Review of a facility investigation dated 11/21/25 showed resident #10 was taken out to eat by the DON and the behavioral analyst. During the outing, the DON administered an Invega injection through the resident's clothing, after the resident refused the medication earlier. The incident review showed the DON stated "Sensory modulation techniques were implemented to improve resident tolerance of the injection procedure. Resident provided sensory items, including keys, a beaded lanyard with textured material, and alcohol wipes, were utilized to provide tactile distraction and reduce perceived	F0684	F-0684 (Continued) **Quality of Care** **CFR(s): 483.25** How the Facility Will Identify Other Residents Affected and the Measures to Be Put in Place are detailed in the plan of corrections. Monitoring and Tracking: The SNF Administrator and Director of Nursing will ensure and document staff training on Invega shots, administering and documenting medications, care plan changes, and Standard Precautions. The new MDS Coordinator will be responsible for documenting care conference meetings, and ensuring that elopements/wandering are addressed at all care conferences and tracked. The Nursing PIP will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Nursing Home Administrator, Director of Nursing, MDS Coordinator, and Social Worker.	

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F0684 SS = D	Continued from page 9 discomfort during administration. For resident and staff safety, and to reduce risk of physical struggle or injury, the ordered medication was administered via intramuscular injection to the left deltoid through clothing, utilizing nursing clinical judgement based on the resident's history of aggression and inability to safely expose the injection site. Site landmarking was confirmed as accurately as possible under the circumstances." Further review showed the resident wasn't interviewed due to him/her being asleep during the investigation. c. Interview with the DON on 4/23/26 at 3:07 PM revealed resident #10 was given recent Invega injections with the guardian's informed consent. The staff discussed trying new distraction techniques and dining outings, as the resident was food motivated, and the guardian agreed to these trial interventions. Further interview revealed the guardian agreed the resident did need the injection to have an overall improved wellbeing and the resident has a high level of paranoid delusions without medications. d. Interview with social services #1 on 4/24/26 at 4:17 PM revealed she had attempted to contact administration due to resident #10 being taken off campus to "sneak a shot" on him/her after s/he refused the medication that morning. This made her uncomfortable and she felt the resident should be able to refuse. She went to investigations to get them to check in on the situation since she couldn't get a hold of administration. 2. Review of the manufacturer prescribing information for Invega Sustenna showed "…Invega Sustenna is intended for intramuscular use only. Do not administer by any other route. Avoid inadvertent injection into a blood vessel. Administer the dose in a single injection; do not administer the dose in divided injections. Inject slowly, deep into the deltoid or gluteal muscle…" 3. Review of Wolter Kluwer's "Lippincott Nursing Procedures [Kindle Version]", 9th edition, 2023 page 2127 through 2143 showed "…IM injection…the site for an IM injection must be chosen carefully, taking into account the patient's general physical status and the purpose of the injection. IM injections shouldn't be administered at inflamed, edematous, or irritated sites or at sites that contain moles, birthmarks, scar tissue or other lesions… IM injections require sterile technique to maintain the integrity of the muscle tissue… avoid distractions and interruptions when preparing and administering medications to prevent medication errors… to locate deltoid injection site	F0684		

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F0684 SS = D	Continued from page 10 find the lower edge of the acromial process and the point on the lateral arm in line with the axilla. Insert the need 1 to 2 inches below the acromial process, usually 2 or 3 finger breadths, at a 90-degree angle….to locate ventrogluteal Have the patient sit, stand, lie laterally, or lie supine. Locate the greater trochanter of the femur with the heel of your hand. Then spread your index and middle fingers from the anterior superior iliac spine to as far along the iliac crest as you can reach. Insert the needle between the two fingers at a 90-degree angle to the muscle…" 4. Review of the facility policy titled "Administering and Documenting Medications" dated 4/1/22 showed "…medications shall be administered in a safe and timely manner, and as prescribed…3. Medications must be administered in accordance with the orders, including any required time frame. Staff should consider individual needs and preferences when evaluating medication administration times…20. Staff shall follow established WLRC infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medication, as applicable.	F0684		