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

Revisions Requested by CMS 6/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53G003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyons ICF/MR at Wyoming Life Resource Center	8204 Highway789 , 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
W0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 5/12/26 through 5/14/26. Also reviewed during the course of the survey was complaint intake 2880614. The following common abbreviations are used throughout this document: RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	W0000	**W-155** **STAFF TREATMENT OF CLIENTS** **CFR(s): 483.420(d)(3)** This STANDARD is not met as evidenced by: Based on review of abuse investigations, staff interview, policy and procedure review, and work schedule review, the facility failed to ensure adequate protections were in place to prevent further potential abuse during an investigation for 1 of 5 allegations of abuse/neglect reviewed.	
W0155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is NOT MET as evidenced by: Based on review of abuse investigations, staff interview, policy and procedure review, and work schedule review, the facility failed to ensure adequate protections were in place to prevent further potential abuse during an investigation for 1 of 5 allegations of abuse/neglect reviewed. The findings were: 1. Review of an investigation report showed an allegation of physical abuse by RN #1 to client #1 which allegedly occurred on 2/7/26. Investigator #1 reported while reviewing video footage on 2/11/26 she observed RN #1 holding the door shut to resident #1 "for about 3-4 minutes." Prior to observing the door being held shut, the investigator observed RN #1 "grabbing the back of [client #1]'s clothing, and swinging [client #1] to the ground." The investigator reported "after about 3-4 minutes. [RN #1] then opened the door and [client #1] came out" and the client "was not being aggressive at the time the door was held shut, or just before [client #1] went into [his/her] room." The following concerns were identified:	W0155	Corrective Action: The facility will take all necessary measures to protect the resident(s), including removing staff from working with the resident(s) when appropriate. Per WLRC policy Protection from Harm (ICF-Chapter 2, Sections a-d, effective 8/08/2025), the decision for placing a staff member on Administrative Review Leave (ARL) is solely with the Facility Administrator or Delegate. When a full investigation is appropriate, if the Facility Administrator or Delegate decides against Administrative Review Leave (ARL), the Facility Administrator or Delegate will email the Investigator(s) at WDH-WLRC-INVESTIGATIONS to document the justification for that decision. This email will be included in the investigation documentation to justify the decision. Staff members will be considered for Administrative Review Leave (ARL) whenever an allegation of abuse or neglect is made involving any WLRC resident.	6/25/2026

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
Stephanie Wright	Stephanie Wright	Facility Coordination Administrator	6/30/2026

7/8/26 - 11:49 AM - POC accepted with an alleged date of compliance of 6/25/26. Stephanie Wright notified.

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W0155	Continued from page 1 a. Review of a "Client Right Investigation report" dated 2/13/26 showed the incident was verified and the determination was made by administration "not to remove" RN #1 or place him on leave pending the outcome of the investigation. b. Review of a "Notice of Conclusions" provided to RN #1 dated 2/13/26 showed following the internal investigation of allegations of abuse, neglect and mistreatment, it was determined the abuse and mistreatment were verified. c. During an interview on 5/14/26 at 9:59 AM investigator #1 confirmed RN #1 (alleged perpetrator) was not suspended during the investigation. She stated RN #1 was working on 2/11/26, the day she was conducting the investigation. When asked why the employee was not suspended, she stated it was the decision of the Administrator. d. Interview with the facility administrator on 5/14/26 at 11:16 AM confirmed she was aware of the incident on 5/11/26 and confirmed RN #1 was not placed on ARL. Further interview revealed the facility had 3rd party review of the incident; however, the 3rd party review was not conducted until after the conclusion of the facility's investigation and the verification of abuse was sent to the employee. e. Review of the work schedule for RN #1 showed the employee worked on 2/11/26 and 2/12/26, and was not working on 2/13/26. 2. Review of the facility's policy "Protection from Harm," effective 8/8/25, showed "...Facility Administrator or Designee...c. Shall require a state-employed staff, contract staff, or volunteer staff to remain off work while an investigation is pending if there is an allegation of abuse, neglect, and/or mistreatment against them..."	W0155	**W-155** **STAFF TREATMENT OF CLIENTS** **CFR(s): 483.420(d)(3)** **(Continued)** Revise the Management Investigative Review Team (MIRT) process to include a review of Administrative Review Leave (ARL) when it has not been implemented, and include that review in the meeting minutes. Revise the WLRC policy Protection from Harm (ICF-Chapter 7, Section a, effective 8/08/2025), and the WLRC Investigation Workflow Checklist for ICF Cases to include the new above MIRT review process. The policy revisions will also include clarifications to the ARL process, and consideration of any effect an incident could have on another resident. All members of the Management Investigative Review Team, Facility Administrator, Residential On-Call (ROC), Administrator On-Call (AOC), Investigator, Human Resource staff, Risk Manager will be trained on the policy, process, and MIRT meeting changes. Responsible Person(s): Facility Administrator or Delegate, Investigators, Quality Assurance Performance Improvement Committee Monitoring/Tracking: The ICF-Quality Assurance Performance Improvement Committee (ICF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events, as presented in monthly reports, to improve event detection, optimize cause analysis, and build best practices. The committee will monitor monthly metrics submitted by the Investigator regarding allegations, whether ARL was used, and if the allegations were verified or unverified.	
W0157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is NOT MET as evidenced by: Based on review of abuse investigations and training documentation, staff interview, and policy and procedure review, the facility failed to ensure appropriate corrective action was taken for 1 of 5 allegations of abuse/neglect reviewed. The findings	W0157		

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W0157	Continued from page 2 were: 1. Review of an investigation report showed an allegation of physical abuse by RN #1 to client #1 which allegedly occurred on 2/7/26. Investigator #1 reported while reviewing video footage on 2/11/26 she observed RN #1 holding the door shut to resident #1 "for about 3-4 minutes." Prior to observing the door being held shut, the investigator observed RN #1 "grabbing the back of [client #1]'s clothing, and swinging [client #1] to the ground." The investigator reported "after about 3-4 minutes, [RN #1] then opened the door and [client #1] came out" and the client "was not being aggressive at the time the door was held shut, or just before [client #1] went into [his/her] room." The following concerns were identified: a. Review of the Management Investigation Review Team meeting minutes for 2/13/26 showed the "Corrective Actions" were "All staff will receive re-training on the facility's resident rights policies. Further review showed the "Systemic Actions" were "Facility Administrator has directed that all staff will be in-serviced on the facility's resident rights policies." b. Review of a "Notice of Conclusions" provided to RN #1, dated 2/13/26 showed following the internal investigation of allegations of abuse, neglect and mistreatment, it was determined the abuse and mistreatment were verified. c. Review of the "Training Progress Summary Pie Chart-WLRC Protection from Harm and Resident Rights Refresher" showed the registration date for the on-line training was 3/11/26 and 92.8 percent of staff had completed the training. Further review showed RN #1 completed the training on 3/26/26, 41 days after the "Notice of Conclusions" was provided. d. Review of the work schedule for RN #1 showed the employee returned to work on 2/15/26, 2 days after the "Notice of Conclusions" was provided. e. Interview with the facility administrator on 5/14/26 at 11:16 AM confirmed RN #1 did not receive training prior to returning to work. 2. Review of the facility's policy "Protection from Harm," effective 8/8/25, showed "...7. Management Investigative Review Team a. The Team will review the findings of investigations and make recommendations as appropriate to meet the safety	W0157	**W-157** **STAFF TREATMENT OF CLIENTS** **CFR(s): 483.420(d)(4)** This STANDARD is not met as evidenced by: Based on review of abuse investigations, staff interview, policy and procedure review, and work schedule review, the facility failed to ensure adequate protections were in place to prevent further potential abuse during an investigation for 1 of 5 allegations of abuse/ neglect reviewed. Corrective Action: The facility will take all necessary measures to protect the resident(s), including removing staff from working with the resident(s) when appropriate. Per WLRC policy Protection from Harm (ICF-Chapter 2, Sections a-d, effective 8/08/2025), the decision for placing a staff member on Administrative Review Leave (ARL) is solely with the Facility Administrator or Delegate. When a full investigation is appropriate, if the Facility Administrator or Delegate decides against Administrative Review Leave (ARL), the Facility Administrator or Delegate will email the Investigator(s) at WDH-WLRC-INVESTIGATIONS to document the justification for that decision. This email will be included in the investigation documentation to justify the decision. Staff members will be considered for Administrative Review Leave (ARL) whenever an allegation of abuse or neglect is made involving any WLRC resident. Revise the Management Investigative Review Team (MIRT) process to include a review of Administrative Review Leave (ARL) when it has not been implemented, and include that review in the meeting minutes.	6/25/2026

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W0157	Continued from page 3 needs of residents served, including recommendations for disciplinary action."	W0157	**W-157** **STAFF TREATMENT OF CLIENTS** **CFR(s): 483.420(d)(4)** **(Continued)** Proof of completion for all recommendations made by the MIRT members must continue to be placed in the Investigator's Proof Book for the incident, and the Google Investigations Follow-up Spreadsheet must be updated. Revise the WLRC policy Protection from Harm (ICF-Chapter 7, Section a, effective 8/08/2025), and the WLRC Investigation Workflow Checklist for ICF Cases to include the new above MIRT review process. The policy revisions will also include clarifications to the ARL process, and consideration of any effect an incident could have on another resident. All members of the Management Investigative Review Team, Facility Administrator, Residential On-Call (ROC), Administrator On-Call (AOC), Investigator, Human Resource staff, Risk Manager will be trained on the policy, process, and MIRT meeting changes. Responsible Person(s): Facility Administrator or Delegate, Investigators, Quality Assurance Performance Improvement Committee Monitoring/Tracking: The ICF-Quality Assurance Performance Improvement Committee (ICF-QAPI) members will focus on measurement systems and metrics related to resident safety and health events, as presented in monthly reports, to improve event detection, optimize cause analysis, and build best practices. The committee will monitor monthly metrics submitted by the Investigator regarding allegations, whether ARL was used, and if the allegations were verified or unverified.	