STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	532503	A. BUILDING B. WING	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River Dialysis Center	11 Shipton Lane , Fort Washakie, Wyoming, 82514

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys from 5/26/26 through 5/28/26. Based on the findings of the survey team it was determined the facility was in compliance with all requirements.	E0000		
V0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 5/26/26 through 5/28/26. The following common abbreviations are used throughout this document: CCHT: Certified Clinical Hemodialysis Technician PCT: Patient Care Technician RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	V0000		
V0726	MR-COMPLETE, ACCURATE, ACCESSIBLE CFR(s): 494.170 The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure 1 of 3 newly admitted patients (#3) had complete medical records. The findings were: 1. Review of the medical record for patient #3 showed s/he was admitted to the dialysis center on 5/7/26. There was no evidence of an order to admit	V0726	V726 Wind River Dialysis Center (WRDC) did not ensure pt #3 had current written orders for re-admission to our facility. We had accepted a "verbal" order from our nephrologist. The verbal order was not entered into the EMR. We went through new patient admissions since 1/1/26 and found 1 pt had a verbal order and was in EMR. CEO and nurses have created a "New Patient Admission check off sheet", along with making new patient packets. The checkoff has been added to the top of the admission packets. The admitting nurse will ensure all items on the check off sheet are completed. The current signed Physician dialysis orders is listed as the first item on the admission sheet. Meeting with RN's 6/24/26 and they were informed that no patient will be accepted to WRDC until new patient dialysis medical information is sent to Nephrologist and the written orders have been received. The new patient will then be informed that they have been accepted to WRDC.	7/10/26

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
Christine Williams	CEO	6/26/26

This plan of correction was accepted on 6/29/26. Chris Williams was notified via email on 6/29/26 at 11:22am. Jenn Jennie 6/29/26

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V0726	Continued from page 1 the patient to the dialysis center, and there was not a current signed order for dialysis treatment. 2. Interview with charge nurse #1 on 5/28/26 at 8:20 AM revealed patient #3 was readmitted to the facility after a three-month hospitalization and rehabilitation stay, and orders were verbally communicated to resume the previous dialysis treatment; however, there is no evidence the verbal orders had been confirmed with the physician. 3. Interview with the medical director on 5/28/26 at 1:17 PM confirmed the facility may readmit patients with verbal orders to resume the most recent dialysis treatment; however, the verbal orders should be followed with a signed order. 4. Review of the "Scope of Service" policy, last reviewed 7/2024, showed "Adults with end stage renal disease will be admitted by a credentialed Nephrologist..." and "A chronic dialysis prescription should be available before treatment is started".	V0726	CEO will create a new binder by July 10, 2026, that will contain divisions for ensuring following up on keeping track on new pt written orders, infection control training for staff, new staff orientation/training and completion, and TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body. 6/17/26 Updated policy # 2-2 Scope of Service and Policy # 2-3 Admission Criteria. Both state "New Patient Admissions require written/signed Nephrology orders" prior to the new patient being accepted at WRDC. 6/17/26 Created "New Patient Admission check off sheet." Admission "packets" have been made with this check off sheet on the top. The packets will be kept in each nurse bottom drawer. The admitting nurse will be responsible in ensuring the check off sheet is complete. 6/17/26 Nurse meeting with the CEO and RN's done to ensure we all know of the new packets and check off Sheet. Each nurse is responsible in keeping "packets" stocked in their desk drawers.	
V0760	GOV-GB RESP FOR STAFF ORIENTATION CFR(s): 494.180(b)(3) The governing body or designated person responsible must ensure that- (3) All staff, including the medical director, have appropriate orientation to the facility and their work responsibilities; This STANDARD is NOT MET as evidenced by: Based on review of personnel files, staff interview, and policy and procedure review, the governing body failed to ensure each staff member received an orientation to the facility, his/her job duties, and how to do the work assigned for 1 of 1 newly hired employees (RN #3) reviewed. The findings were: 1. Review of the personnel file for RN #3 showed she was hired on 1/21/26. Further review of RN #3's personnel file showed no documentation she had been oriented to the facility upon hire. 2. Interview with charge nurse #1 on 5/28/26 at 8:21 AM revealed RN #3 had only been trained on central lines and other topics; however, nothing had been documented. 3. Review of the policy and procedure "Direct Care Provider Orientation", last reviewed 7/2024, showed "New Direct Care Providers (sic) employees will	V0760	V0760 WRDC failed to ensure newly hired RN#3 received orientation. Audit on other staff that may not have had orientation when they were hired. Went through new hires since 1/1/26 and only RN# 3 was hired in 2026. The CEO will ensure all new staff receive orientation and education for the job they were hired for, and bring information to the Governing body meetings. 6/18/26 We updated our educational information. And only trained CCHT's with Bio-Med training or trained Nurses that have completed the education can train new employees. CCHT trainers have completed all the educational material themselves, have completed the Machine training in Texas and have been employed with WRDC for 7 years or more. Updated the study book to the: "Sixth addition of the Core Curriculum for Dialysis Technician" This also includes 7 Module tests that go with each chapter of the study book.	7/10/26

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V0760	Continued from page 2 follow an orientation schedule to ensure trainees are capable of meeting the criteria as defined in the job description & Network #15 PCT/RN Guidelines. Employees of the WRDC will be familiar with the unit's operational policies and procedures..." The policy outlined educational modules which included Today's Dialysis Environment, The Person with Renal Failure, Principles of Dialysis, Vascular Access, Hemodialysis Procedures & Complications, and Water Treatment.	V0760	6/18/26 Policy # 4-1 updated to represent the new study book, study/clinical schedule, and operational policies and procedures. RN # 3 will start her "Direct Care Provider Orientation" on 7/6/26, supervised by the CEO. CEO will create a new binder by July 10, 2026, that will contain divisions for ensuring following up on keeping track on new pt written orders, infection control training, new staff orientation and completion, TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body.	
V0113	IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is NOT MET as evidenced by: Based on observation, staff interview, policy and procedure review, and review of CDC (Centers for Disease Control) guidelines, the facility failed to ensure effective infection control measures related to hand hygiene during random observations which affected 5 patients (#1, #2, #8, #9, #10). The findings were: 1. Observation on 5/26/26 at 2:50 PM showed charge nurse #1 was performing a dressing change on a femoral venous catheter for patient #2. After the charge nurse removed the old dressing, she removed her gloves and without performing hand hygiene donned new gloves prior to placing a new dressing on the catheter site. 2. Observation on 5/27/26 at 9:16 AM showed CCHT #1 washed her hands and donned gloves prior to starting the discontinuation of patient #1's dialysis treatment at station #2. Patient #1 had a central venous catheter (CVC). At 9:19 AM CCHT #1 removed her gloves and without performing hand hygiene donned new gloves and placed a clean field under the CVC ports. After disconnecting the venous blood line CCHT #1 removed her gloves and without performing hand hygiene donned new gloves and assisted the patient with his/her chair. CCHT #1 removed those gloves and without performing hand hygiene donned new gloves and disconnected the arterial port. 3. Observation on 5/27/26 at 5:45 AM showed RN #1, after locating and palpating patient #10's access site, removed her gloves and without performing	V0113	**V0113 Education** Infection Control Education will be given by Registered Nurses and overseen by the CEO. The initial infection control education was provided by Clinical supervisor on 2/22/26 at our last annual mandatory meeting. The education will be followed by a biannual meeting on 07/16/26 and educational training videos which are due by 7/31/26. CEO will create a new binder by July 10, 2026, that will contain divisions for keeping track on new pt written orders ensuring following up on staff infection control training, and TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body. Annual Infection Control meetings will be Changed from the Annual Staff Metting to biannual meetings. First mandatory biannual meeting will be held July 16, 2026 at 3pm at Wind River Dialysis Center. Education: 1. Policies and procedures related to infection control. 2. Visual Hands-on education 3. Practice Use of "dummy CVC chest and arm"	7/10/26

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V0113	Continued from page 3 hand hygiene donned new gloves to apply an antiseptic solution over the cannulation sites. 4. Observation on 5/27/26 at 7:19 AM showed RN #3 obtained medication for administration to patient #8 at station 11. She donned gloves without first performing hand hygiene. After medication administration RN #3 removed her gloves and did not perform hand hygiene. 5. Observation on 5/27/26 at 7:25 AM showed RN #3 did not perform hand hygiene, and did not don gloves before approaching patient #9 at station 1. RN #3 wiped the injection port with an antiseptic wipe and injected the medication. RN #3 discarded the needle and syringe into the sharp's container and performed hand hygiene. 6. Observation on 5/27/26 at 9:45 AM showed CCHT #2 performed hand hygiene and donned clean gloves to disconnect the bloodlines of patient #10 aseptically. CCHT #2 removed her gloves and without performing hand hygiene donned new gloves before removing the needles, holding the dressing in place, and applying a bandage. 7. Interview with RN #1 on 5/27/26 at 7:55 AM revealed it was the expectation of the facility to perform hand hygiene after taking off used gloves and donning new gloves. 8. Review of the policy "Initiation of Hemodialysis", last reviewed 7/2024, showed "Hemodialysis will be initiated in a manner that ensures the safety of the patient and adequacy of treatment. UNIVERSAL PRECAUTIONS will be followed..." 9. Review of the CDC "Clinical Safety: Hand Hygiene for Healthcare Workers" guidelines retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety/on 6/5/26 at 10:28 AM showed gloves should be worn when needed for "Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment." Gloves should be changed "...If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs." In addition, the guidelines showed "Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves. Remember to remove gloves carefully to prevent hand contamination as dirty	V0113	**V0113 Education** Infection Control Education will be given by Registered Nurses and overseen by the CEO. The initial infection control education was provided by Clinical supervisor on 2/22/26 at our last annual mandatory meeting. The education will be followed by a biannual meeting on 07/16/26 and educational training videos which are due by 7/31/26. CEO will create a new binder by July 10, 2026, that will contain divisions for keeping track on new pt written orders ensuring following up on staff infection control training, and TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body. Annual Infection Control meetings will be Changed from the Annual Staff Metting to biannual meetings. First mandatory biannual meeting will be held July 16, 2026 at 3pm at Wind River Dialysis Center. Education: 1. Policies and procedures related to infection control. 2. Visual Hands-on education 3. Practice Use of "dummy CVC chest and arm" with check off sheet 4. CDC Dialysis Safety: Video Infection Prevention in Dialysis Settings. All staff will complete the video by July 31, 2026 and Q 6 months forward. Education will be supervised and given out by the CEO, or nurses. Monthly Audits from CDC NHSN by RN's and Entered into Monthly NHSN reports. Starting July 6th, 2026, Overseen by CEO a. Hand Hygiene b. Hemodialysis catheter connection/ disconnection c. Hemodialysis Exit Site Care d. Arteriovenous fistula/graft cannulation/ decannulation e. Dialysis /station Routine Disinfection f. Injection safety/ Med prep g. Injection safety/ med administration	

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

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V0113	Continued from page 4 gloves can soil hands."	V0113		
V0132	IC-TRAINING & EDUCATION CFR(s): 494.30(a)(1)(i) Infection Control Training and Education Infection control practices for hemodialysis units: Intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is NOT MET as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure 1 of 1 newly hired staff members (RN #3) received training and education in infection control. The findings were: 1. Review of the personnel file for RN #3 showed she was hired on 1/21/26. Further review of RN #3's personnel file showed no documentation she had received training in infection control upon hire. 2. Interview with charge nurse #1 on 5/28/26 at 8:21 AM revealed RN #3 was unable to participate in the facility's annual infection control inservice which was held in February. The charge nurse confirmed no documentation of infection control training was available.	V0132	V132 WRDC failed to ensure RN #3 had Infection control and Training Education when she was hired 1/21/26. 6/18/26 Policy # 4-1 updated to represent the new study book, study/clinical schedule, and operational policies and procedures. RN # 3 will start her "Direct Care Provider Orientation" on 7/6/26, supervised by the CEO. Audit on other staff that may not have had orientation when they were hired. Went through new hires since 1/1/26 and only RN #3 was hired in 2026. CEO will create a new binder by 7/10/26 that will contain divisions for ensuring following up on keeping track on new pt written orders, Infection control training, new staff orientation/training and completion, TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body.	7/10/26
V0506	PA-IMMUNIZATION/MEDICATION HISTORY CFR(s): 494.80(a)(3) The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. This STANDARD is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure 1 of 3 newly admitted patients (#1) were screened for tuberculosis prior to the initiation of treatment. The findings were: 1. Review of the medical record for patient #1 showed s/he was admitted to the dialysis center on 4/23/26. There was no evidence patient #1 had been screened for tuberculosis prior to the initiation of dialysis treatments at the center.	V0506	V506 WRDC failed to ensure Patient #1 was screened for TB with their new admission to facility. Patient #1 was administered his PPD on 5/29/26 and read negative on 6/1/26. TB audit was completed on 6/26/26 by CEO on patients admitted 1/1/26 to current. 6/17/26 Created "New Patient Admission check off sheet." Admission "packets" have been made with this check off sheet on the top. The packets will be kept in each nurse bottom drawer. The admitting nurse will be responsible in ensuring the check off sheet is complete. PPD upon admission is # 16.	6/17/26

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V0506	Continued from page 5 2. Interview with charge nurse #1 on 5/28/26 at 12:47 PM revealed the results of the patient's tuberculosis screening test could not be located. 3. Review of the "Scope and Service" policy and procedure, last reviewed 7/2024, showed "...The Wind River Dialysis Center does not accept patients who...b. Have infectious tuberculosis."	V0506	6/17/26 Nurse meeting with the CEO and RN's done to ensure we all know of the new packets and check off Sheet. Each nurse is responsible in keeping "packets" stocked in their desk drawers. CEO will create a new binder by 7/10/26 that will contain divisions for ensuring following up on keeping track on new pt written orders, infection control training, new staff orientation/training and completion, TB upon admission and annually. This binder will be reviewed monthly by the CEO and the findings presented at the monthly QAPI meeting until compliance is met and then periodically thereafter to ensure the deficiency has been corrected. The results of the audits will be presented to the governing body.	