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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 2/14/23 through 2/15/23. The survey was prompted by complaint intakes WY00003523 and WY00003532. The following common abbreviations are used throughout this document. BIMS- Brief Interview for Mental Status CNA- Certified Nursing Aide DON- Director of Nursing EMS- Emergency Medical Services MDS- Minimum Data Set pt- patient	F 000		
F 600 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 observation, review of facility incident reports, review of medical records, staff interview, and review of policy and procedures, the facility	F 600	F600 1. Resident #1 was identified as being affected. Resident exhibited signs of distress and injury at the time of the incident and for remainder of night. 2. No other residents were identified as being affected. However, all residents have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/8/2023

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 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.

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F 600	Continued From page 1 failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 7 sample residents (#1) reviewed for abuse. This failure resulted in harm to resident #1, who had injuries including a bloody nose, a "goose egg" to the forehead, and complaints of pain that required transport to the emergency department (ED) for evaluation. The findings were: Review of the admission MDS assessment dated 1/28/23 showed resident #1 had diagnoses which included renal insufficiency, non-Alzheimer's dementia, malnutrition, and asthma. Further review of the MDS showed the resident wore a wander/elopement alarm, required daily antipsychotic medications and frequent antianxiety medications. Review of the BIMS score showed the resident had a score of 6 out of 15, signifying severe cognitive impairment. Review of the care plan for the resident dated 1/19/23 showed "the resident is an elopement risk/wanderer related to disoriented to place. Resident wanders aimless, significantly intrudes on the privacy or activities." Further review of the care plan showed "Upon admission [resident name] was easily agitated and could become verbally and physically aggressive (especially in late afternoon/evenings)." Interventions included "COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated." Review of the nursing progress note dated 1/24/23 at 7:30 PM and authored by LPN #1 showed the resident was going in and out of other	F 600	3. The staff member was immediately removed from the facility at the time of the incident report and was subsequently terminated upon completion of investigation and substantiation of abuse. Mandatory re-education of all staff members about abuse policies including types of abuse/neglect, prevention of abuse, and reporting allegations was initiated within 24 hours of incident. New education including interventions for dementia with behaviors was also completed with all staff members (in house and agency) over the next 2 weeks. 100% compliance of staff education will be completed by 3/15/2023 4. Administrator and/or designee will conduct random observations of staff interactions with at least 3 non-interview able residents. In addition interviews will be conducted with at least 3 residents on each unit (North and South). The resident interviews will address how the resident is being treated by staff and others. Interviews and observations will be conducted weekly for a period of at least 3 months then randomly thereafter. Resident #1 will be included in interviews so early interventions can be initiated as needed.	3/15/23

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F 600	Continued From page 2 resident's rooms and throwing things. S/he was trying to hit other residents. Further review of this nursing progress note entry showed " ...directed this patient to [his/her] room and got there and patient went down to the floor. This nurse was trying to get under this pt's arms to assist [him/her] and around [his/her] chest and got [him/her] up off the floor while CNA was taking care of the resident's roommate. The resident was over [his/her] bed and grabbed this nurse by the left wrist and swung [his/her] fist punching this nurse in the right temple causing this nurse to fall and unable to control fall landing with right shoulder to this resident's nose and face. The resident's nose began to bleed and this nurse tried to stop it and get some tissues to do so and this pt stated to this nurse to get away from [him/her] or [s/he] would kill this nurse before [s/he] got killed." On 1/24/23 an incident report was initiated related to this incident showing LPN #1 was suspended from duty, and law enforcement was called the night of the incident. The following concerns were identified: 1. Review of the facility's incident report initiated on 1/24/23 showed the resident was assessed by the facility on 1/24/23 at approximately 9:45 PM and noted to have "a bloody nose, a goose egg on [his/her] forehead, and is complaining of rib pain." It was determined the resident's injuries required evaluation at the ED. 2. Review of the nursing progress note dated 1/24/23 at 11:40 PM showed "Resident left facility at this time via stretcher/EMS to emergency department..." 3. Further review of the facility's incident report showed CNA #1 was identified as the CNA who	F 600	5. Administrator and/or designee will report results of observations and resident interviews to QAPI committee monthly for the next 90 days to monitor for any concerns regarding staff interactions with residents. The QAPI committee will evaluate results to determine if current plan of correction is effective or if additional training is needed and will revise plan as necessary to ensure compliance. 6. Local victim advocacy group is currently working with victim/Resident #1 and his family. Resident #1 has advanced dementia and does not exhibit signs of distress at the time of this writing, but ongoing monitoring will be conducted by social worker and counselors.	

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F 600	Continued From page 3 was in the resident's room at the time of the incident. CNA #1 told the facility he was initially afraid to tell the truth about the incident, but he did see LPN #1 "cock back his arm and hit" resident #1. Additionally, the incident report showed CNA #2 told the facility she saw LPN #1 in the nurse's station after the incident. The LPN was visibly upset and when CNA #2 asked him what happened he told her, "I f*cking hit him." CNA #2 reported LPN #1 later told her he had fallen on the resident and his shoulder hit the resident. 4. Review of a statement written by CNA #1 dated 1/27/23 at 3:29 PM showed "...after the new resident fell down like 5 times [LPN #1] dragged the new resident in [his/her] room and the new resident got up and tried to attack [LPN #1] again [LPN #1] took the resident down another time in [his/her] room and had the new resident in a head lock and was choking [him/her] and after the new resident tried to bite him [LPN #1] picked [the resident] up and slammed [him/her] on the bed I after that the new resident hit [LPN #1] in the face broke his glasses and [LPN #1] hit the new resident back with a closed fist how I know it was a closed fist is because he cocked back his arm and hit him". CNA #1 was on leave at the time of the investigation and unavailable for interview. 5. Observation of resident #1 on 2/14/23 from 1:45 PM to 3:15 PM showed the resident in the common area of the secure unit and regularly stood over and yelled at residents who were seated. Staff frequently redirected the resident by attempting to divert his/her attention to other things, such a magazines, or by attempting to convince the resident to go to his/her room. This redirection would only be effective for a short time	F 600		

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F 600	Continued From page 4 before the resident was once again yelling at staff or other residents. An attempt to interview the resident during the observation was unsuccessful. 6. Interview with the DON on 2/14/23 at 10:30 AM confirmed interviews with staff members in the course of the facility's investigation of the incident resulted in the facility calling law enforcement with new information. Review of the facility's incident report showed LPN #1 was arrested. 7. Interview with the DON on 2/15/23 at 11 AM revealed it was the desire and intent of the facility to prevent all abuse for all residents, and confirmed the facility's investigation had shown that abuse occurred. 8. Review of the policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated 2001 showed "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation ...The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the objectives."	F 600		

F600

1. Resident #1 was identified as being affected. Resident exhibited signs of distress and injury at the time of the incident and for remainder of night.

2. No other residents were identified as being affected. However, all residents have the potential to be affected.

3. The staff member was immediately removed from the facility at the time of the incident report and was subsequently terminated upon completion of investigation and substantiation of abuse. Mandatory re-education of all staff members about abuse policies including types of abuse/neglect, prevention of abuse, and reporting allegations was initiated within 24 hours of incident. New education including interventions for dementia with behaviors was also completed with all staff members (in house and agency) over the next 2 weeks.
100% compliance of staff education will be completed by 3/15/2023

4. Administrator and/or designee will conduct random observations of staff interactions with at least 3 non-interview able residents. In addition interviews will be conducted with at least 3 residents on each unit (North and South). The resident interviews will address how the resident is being treated by staff and others.
Interviews and observations will be conducted weekly for a period of at least 3 months then randomly thereafter. Resident #1 will be included in interviews so early interventions can be initiated as needed.

5. Administrator and/or designee will report results of observations and resident interviews to QAPI committee monthly for the next 90 days to monitor for any concerns regarding staff interactions with residents. The QAPI committee will evaluate results to determine if current plan of correction is effective or if additional training is needed and will revise plan as necessary to ensure compliance.

6. Local victim advocacy group is currently working with victim/Resident #1 and his family. Resident #1 has advanced dementia and does not exhibit signs of distress at the time of this writing, but ongoing monitoring will be conducted by social worker and counselors.