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 12/28/2023

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 12/26/23 to 12/28/23. The survey was prompted by complaint intakes WY00003753. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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, medical record review,	F 600	Resident # 4 was identified was identified as being affected. Resident was moved to a new room upon return to facility on 12/11/23. Resident # 4 voiced feeling comfortable and safe in his new room Resident # 2 was identified as being affected. Resident was immediately redirected to his room at the time. A motion alarm was placed on his door. Additional staff utilized in area during ADL care and meal times to ensure continuous observation of Resident #2. WRC has identified the potential for resident to resident altercations to affect all individuals in the mens demential unit. Additional staff is provided during meal times and ADL care times. QAPI team has started PIP to identify risk factors and safety concerns for all residents and educate staff to identify and de-esculate potential aggressive interactions.	12/12/23 12/29/23 12/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/5/24

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 resident representative and staff interview, state survey agency incident database review, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 2 of 4 sample residents (#2, #4) reviewed for abuse allegations. This failure resulted in actual harm to resident #2 and resident #4 who sustained injuries during a resident-to-resident altercation. The findings were: 1. Review of the facility incident reported to the state survey agency incident database dated 12/5/23 and timed 6 PM showed resident #2 and resident #4 were involved in a resident-to-resident physical altercation in the room of resident #4. The residents were observed on the floor with resident #2's arm wrapped around the head of resident #4. Resident #4 was observed hitting resident #2, with a closed fist, in the face. Immediate interventions included removing resident #2 from the room and assisting him/her to his/her room at the opposite end of the unit. The residents were placed on increased monitoring to prevent interactions. Both residents were placed on neurological evaluations and a stop sign was placed on the doorway of resident #4 to prevent others from entering his/her room. Further review showed both residents sustained injuries as a result of the altercation. 2. Observation on 12/26/23 at 4 PM showed resident #4's room was no longer located on the secure unit near resident #2. 3. Review of the significant change MDS assessment dated 10/28/23 showed resident #4 had a BIMS score of 4 out of 15, which indicated severe cognitive impairment, and diagnoses	F 600		

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F 600	Continued From page 2 which included non-Alzheimer's dementia, delusions, and an anxiety disorder. Further review showed the resident walked without assistance, had no skin problems, no fractures, and received antianxiety and antidepressant medications during the 7-day look-back period. The following concerns were identified: a. Review of a progress note dated 12/5/23 and timed 8:27 PM showed "...This nurse was called into another [resident #4's] room by [CNA #5] in the [locked unit] at approximately 1800 [6 PM]. When this nurse arrived in room [resident #4] was on the floor next to the empty bed in room with other community members [other resident's] arm around [his/her] neck ina [sic] head lock, both community member's legs were intertwined, and [resident #4] hit other community member in the face, under the left eye and left side of nose, with a closed hand. As staff were pulling community members apart [resident #4] hit other community member in the face again in the same spot with a closed fist. Prior to incident [resident #4] was noted pacing in [his/her] room. [CNA #5] stated that she had been in another community members room with the door shut providing cares when she heard a commotion. Whensheexited [sic] room she heard other community member say "get off me, get off me". She noticed other community member wasn't in [his/her] chair and entered room to find community members on the floor intertwined. [CNA #5] stated she then immediately came and got help. Community members were pulled apart from one another. Other community member was immediately taken out of [resident #4's] room and to [his/her] own. Head to toe physical assessment performed. [Resident #4] had no red areas noted to bilateral lower extremities or bilateral upperextremities [sic]. Laceration approximately 1	F 600		

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F 600	Continued From page 3 cm long noted to lobe of right ear. Hematoma noted to top right side of head. No other red or areas of discoloration noted/reported atthis [sic] time. No other injuries noted at this time. Neurological checks initiated related to altercation and unwitnessed fall. Stop sign placed on [resident #4's] door to dissuade other community members from entering [his/her] room. When asked what happened [resident #4] stated "What are you going to do about that asshole? If [s/he] comes back in here again I will kick [his/her] ass again. [S/He's] tough, but so am I..." b. Review of a progress note dated 12/8/23 and timed 11:01 AM showed "...Resident was in Res [resident] on Res altercation, has bruising to hand, and face. Resident stated [his/her] lower back was hurting today. PRN [as needed] APAP [analgesic] administered. Resident reports it is effective..." c. Review of a hospital discharge note dated 12/9/23 showed the resident had rib fractures and a lumbar transverse process fracture. d. Review of a physician note dated 12/17/23 showed "...[S/He] is being seen today for follow up rib fractures, decreased appetite, debility. Rib Fractures: Patient with recent hospitalization for rib fractures after an altercation with another resident and fall. Patient reports right upper, outer chest pain to which Tylenol [analgesic] is effective..." e. Interview with the resident representative for resident #4 on 12/27/23 at 11:53 AM confirmed the resident's room was moved outside the secure unit, away from resident #2. Further interview, confirmed the resident sustained 3 broken ribs and a broken vertebra, had a hematoma to his/her head, had a bruise to his/her eyes, and had a dark bruise to his/her hand following the altercation.	F 600		

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F 600	Continued From page 4 3. Review of the quarterly MDS assessment dated 10/7/23 showed resident #2 had a BIMS score of 6 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia. Further review showed the resident received antipsychotic medication and had behavioral symptoms not directed toward others on 1 to 3 days during the look-back period. The following concerns were identified: a. Review of a progress note dated 12/5/23 and timed 8:59 PM showed "...This nurse was called into another community member's room by [CNA #5] in the [locked unit] at approximately 1800 [6 PM]. When this nurse arrived in room [resident #2] was on the floor next to the empty bed in room with [his/her] arm around other community member'sneck [sic] in a head lock, both community member's legs were intertwined, and other community member hit [resident #2] in the face, under the left eye and left side of nose, with a closed hand. As staff were pulling community members apart other community member hit [resident #2] in the face again in the same spot with a closed fist. Prior to incident [resident #2] was sitting in chair out in common area. [CNA #5] stated that she had been in another community members [sic] room with the door shut providing cares when she heard a commotion. Whenshe [sic] exited room she heard other community member say "get off me, get off me". She noticed [resident #2] wasn't in [his/her] chair and entered room to find community members on the floor intertwined. [CNA #5] stated she then immediately came and got help. Community members were pulled apart from one another. [Resident #2] was immediately taken out of other community members [sic] room and to	F 600		

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F 600	Continued From page 5	F 600		

[his/her] own. Once in [resident #2's] room [resident #2] began settling down and sat in [his/her] recliner. This nurse performed a head to toe physical assessment. No red or discolored areas noted to torso bilateral lower extremities, upper left extremity or head at this time. A skin tear approximately 2 cm x 1 cm was noted to right lateral wrist. [Resident #2] had blood noted to the left corner of [resident #2's] mouth and lower lip. Thorough oral assessment was completed and no injury to mouth or face was noted. No hematomas noted to head. [Resident #2] did complain of right wrist pain and a headache at this time. Neurological checks initiated related to unwitnessed fall and being hit in the head. Staff hung a stop don't enter banner over other community members door to dissuade [resident #2] from entering room again."

b. Review of a progress note dated 12/6/23 and timed 8:10 PM showed the resident "...remains on alert charting post unwitnessed fall and resident to resident altercation, with injury to left wrist, dressing on left wrist clean dry and intact. resident [sic] denies pain and discomfort at this time. will [sic] continue to monitor through out [sic] shift..."

4. Interview with RN #1 on 12/27/23 at 12:40 PM revealed she heard resident #4 yelling for resident #2 to get out of his/her room and upon entering witnessed the residents punching each other and fall to the floor while fighting. The nurse revealed both residents received injuries from the fight. Further interview revealed the residents were immediately separated, both residents remained in their own rooms the remainder of the night, and a stop sign was placed across the doorway of resident #4.

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F 600	Continued From page 6 5. Interview with RN #2 on 12/27/23 at 9:50 AM revealed resident #4 was sent to the hospital 3 days after the altercation due to chest pain and the family refused to allow the resident to return unless the facility could ensure the resident's safety. 6. Interview with the DON on 12/28/23 at 12:05 PM revealed resident #4 did not complain of pain right after the altercation but when s/he did, it was of chest pain so s/he was sent to the hospital on 12/9/23. At that time, the facility was notified of the fractures to resident #4 by the hospital. The DON revealed the facility was not sure if the fractures were from the resident-to-resident altercation because the resident was mostly independent and did not have pain immediately after the altercation. The DON did confirm resident #2 received a skin tear to the right wrist and resident #4 received a laceration to the right ear lobe, a hematoma to top of his/her head, bruising to the left hand, face, and right upper chest, and required more staff assistance for a few days. 7. Review of the facility policy dated September 1999 titled "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" showed "...all residents will be protected from abuse and neglect ...1. Abuse, is...the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish..."	F 600		