STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

(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 5/21/24 to 5/22/24. The survey was prompted by complaint intakes WY000003810, WY00003832, WY00003888, and WY00003891.	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 medical record review, staff interview, and review of incident and quality improvement documentation, the facility failed to ensure residents were free from physical abuse by other residents for 2 of 10 sample residents (#2, #5), resulting in harm to resident #5 who suffered a fracture. The findings were: 1. Review of the 2/25/24 admission Minimum Data Set (MDS) assessment showed resident #2 (victim) had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 (significant cognitive	F 600	F600 Abuse Corrective Action: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes	6/13/24

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

Electronically Signed | 06/13/2024

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F 600	Continued From page 1 impairment). The diagnoses included dementia, COPD, gout, pain and skin cancer. 2. Review of the 4/3/24 comprehensive MDS assessment showed resident #5 (victim) had a BIMS score of 9 out of 15 (moderate cognitive impairment) and diagnoses including diabetes, hypertension and respiratory failure. 3. Review of the 3/26/24 admission MDS assessment showed resident #1 (perpetrator) had a BIMS score of 4 out of 15 (significant cognitive impairment). The diagnoses included dementia, stroke with right sided weakness, and diabetes. 4. Review of an incident report dated 4/26/24 showed a resident-to-resident altercation between resident #1 and resident #5 which resulted in injury to resident #5. Resident #5 stated resident #1 came into his/her room and was agitated. Resident #1 pushed resident #5 backwards and s/he hit their head and sustained a skin tear to the arm. The resident also complained of back pain. Resident #5 was sent to the emergency room where it was determined s/he had a closed fracture of the spinous process of the thoracic vertebra. The report showed resident #1 was redirected and placed on "increased supervision." 5. Interview with the director of nursing (DON) on 5/22/24 at 11:50 AM revealed the facility implemented a quality assessment process improvement (QAPI) program addressing the resident-to-resident abuse that occurred between residents #1 and #5 for failure to protect facility residents from abuse. Resident #1 was placed on	F 600	of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Resident placed on video monitoring to ensure 1:1 supervision of male resident during waking hours and when he exits his room. Alternate placement has been sought out and resident has been accepted to another facility. We are currently awaiting an opening in the facility at which time we will arrange transportation. IDENTIFICATION: The facility has determined that all residents residing at the community are potentially at risk. Interviewable residents currently residing in the community will be interviewed by DON/SSD/NHA or designee to identify if any other resident may have experience mistreatment of any kind. The DON/designee will review the last 7 days of incidents/accidents for bruise, skin tear, injuries of unknown origin in the community to determine any pattern or trends. SYSTEMIC CHANGES: On or before 6/13/2024 the DON/designee will reeducate ALL staff who work with residents residing at Cottonwood on Abuse Prevention. Training will include behavior management and working with residents with behaviors to decrease risk of aggression towards other residents. An	

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F 600	Continued From page 2 increased observation while awake. Review of the QAPI program initiated after the resident-to-resident altercation between residents #1 and #5 showed all residents residing in the community were potentially at risk and the facility provided staff training including behavior management and working with residents with behaviors to decrease the risk of aggression towards other residents and a date of compliance of 5/8/24. 6. Review of an incident report dated 5/9/24 showed staff found resident #1 in the room of resident #2. Resident #2 stated resident #1 hit him/her on the shoulder and resident #1 stated, "I'm going to hit [him/her] again." There was "slight redness" on the shoulder of resident #2. Resident #1 was placed on 1:1 observation while awake and plans were made to transfer resident #1 to another facility as soon as a room became available. 7. During an interview on 5/22/24 at 4:18 PM the DON stated resident #1 was on 1:1 observation and the altercation between resident #1 and #2 occurred at shift change when the resident was unsupervised. 8. Review of the facility investigation from the resident-to-resident altercation between residents #1 and #5 on 4/26/24 showed the facility substantiated the allegation. Further review showed the facility investigation of the altercation between resident #1 and #2 on 5/9/24 was also substantiated.	F 600	attendance sheet will be kept and reconciled with the active staff roster and those staff unable to attend in-servicing will be provided 1:1 reeducation. Abuse prevention and reporting will be included in new hire orientation. A dementia expert will be in facility on 6/12/24 and 6/13/24 to provide two 4.5 hour workshops to all staff on dementia training. MONITORING: Ongoing monitoring will continue through the incident reporting system, the grievance management system, resident and family interviews and ombudsman feedback. DON/ADON/SS will review incident/accident documentation on residents residing at community 3 times weekly and PRN for 3 months and then weekly for 1 month and the PRN. On the spot reeducation will occur at that time with the staff member who is present during an incident. Counseling will be provided as indicated. Any issues identified will be trended and reviewed in the facility QAPI meeting to ensure the plan has been implemented, sustained, and evaluated for its effectiveness. DATE OF COMPLIANCE: 06/14/2024	