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 05/23/2024

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 5/22/24 to 5/23/24. The survey was prompted by complaint intake WY00003886.	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 and resident interviews, and review of incident documentation, the facility failed to ensure residents were free from abuse by other residents for 1 of 3 allegations of abuse reviewed (#1). Resident #1 experienced physical and psychosocial harm as a result of an interaction with another resident. The findings were: 1. Review of the 4/6/24 admission Minimum Date Set (MDS) assessment showed resident #1 (victim) had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition,	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/24/24

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 and had the ability to understand others and makes self understood. 2. Review of the 3/30/24 admission MDS assessment showed resident #2 (perpetrator) had a BIMS score of 1, indicating severe cognitive impairment, and a diagnosis of dementia. 3. Review of an incident report showed on 4/28/24 resident #1 came out of his/her room and told licensed practical nurse (LPN) #1 that resident #2 had thrown a water cup at him/her. The cup struck the resident in the face causing a small scratch near the mouth and soaked him/her in water. The facility's conclusion of their investigation was "...conclude that a physical resident on resident altercation did occur. Residents were immediately separated and a temporary room move was conducted that day... [resident #2] was then moved to a private room on 4/30/24 on the men's secure unit...[Resident #1] was noted by some staff to be more somber after the incident but had no major behavioral changes." 4. Review of a progress note dated 4/28/24 showed resident #1 stated his/her roommate threw a water pitcher at him/her. There were two marks on the resident's face; a small scratch on the upper lip and one on the right upper cheek. The resident's clothes were covered with water. The note further showed "Client is afraid to go back to [his/her] room." Another note dated 4/29/24 showed "Resident did not enter into his original room this shift, stating [s/he] did not want to be around [his/her] roommate. Resident is currently staying in a temporary room at this time."	F 600	Resident #1 was identified as being affected by altercation. Resident verbalized fear and displayed social withdrawl after altercation and for the next few days. Resident #1 was moved to another room for the night and following night also offered a permanent room move to that location. Resident declined and requested to move back to room once resident #2 was moved to a different room. No other residents were identefied as being affected. The facility recognizes the potential for all other residents to be affected. Resident #2 was not affected by the altercation. Resident voiced no recall of incident when asked, resident does have dementia. Resident was moved to a private room in a different area of the building. No behavioral changes were noted.	4/30/24 4/30/24

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F 600	Continued From page 2 5. On 5/23/24 at 8:38 AM resident #1 stated s/he did not have any issues with their current roommate, but had issues with the previous one. When asked what happened, the resident stated "[name of resident #2] tried to kill me." When asked for details, the resident stated resident #2 took a water mug and "...scratched my face all to hell." When asked how that made him/her feel, the resident stated "I'm scared of [him/her]." The resident stated s/he doesn't see the other resident as much now, except in the dining room "...but there are security cameras there." 6. An interview with resident #2 was attempted on 5/23/24 at 9:43 AM, but the resident didn't recall an incident with a roommate. 7. During an interview on 5/23/24 at 9:50 AM LPN #1 stated resident #1 told her that resident #2 had thrown a water mug at him/her. She stated the resident had two marks on his/her face; one on the forehead and one on the cheek. She stated water was all over. She further stated resident #1 was alert and oriented and after the incident told her that s/he was afraid of resident #2. She stated after the incident resident #1 stayed in the common area with staff the rest of the day, which was unusual for him/her. 8. On 5/23/24 at 10:08 AM the administrator confirmed the incident involving residents #1 and #2. She stated resident #1 refused to go back to his/her room "as long as that [guy/gal] is there." When asked what had been done since the incident, the administrator stated around the time of the incident staff were assigned chapters 1-3 in the MANDT book, which covered triggers, communication, de-escalation, etc. However, she	F 600	QAPI team met on 6/20/24 and discussed incident and training with team including Medical Director. Facility has developed weekly check in with all residents through out facility to enhance monitoring for this and other incidents that may occur. Will be discussed weekly or as needed at ad hoc QAPI meeting and at quarterly QAPI meeting to ensure compliance. Staff completed training for de-esculation, facility has begun to develop education library to ensure timely staff education for other incidents that may occur.	6/20/24 6/14/24

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F 600	Continued From page 3 stated not all staff had completed the training. When asked if the incident had been reviewed in quality assurance, she stated they review abuse incidents but they had not had a QA meeting since the incident. The next meeting was in June.	F 600		