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 12/12/2024

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 recertification survey was conducted by Healthcare Licensing and Surveys from 12/9/24 through 12/12/24. Also reviewed in the course of the survey were complaint intakes WY00003941, WY00003976, WY00004005, WY00004031, WY00004038, WY00004039, and WY00004079. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MA-C: Certified Medication Aide DON: Director of Nursing RN: Registered Nurse LPN: Licensed Practical Nurse MDS: Minimum Data Sheet BIMS: Brief Interview for Mental Status 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	F 600		

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

Administrator | 1/16/2025

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.

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 12/12/2024

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 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, incident review, staff interview, and policy and procedure review, the facility failed to protect the residents' right to be free from physical abuse by a resident for 3 of 12 sample residents (#29, #71, #73) and verbal abuse by a staff member for 1 of 12 sample residents (#72). This failure resulted in actual physical harm to resident #71 and mental harm, based on a reasonable person, to resident #72. The findings were: 1. Review of an incident report dated 10/25/24 showed the administrator and nurse manager were notified at approximately 9:15 AM of a verbal incident involving CNA #1 and resident #72. The incident report showed resident #72 was upset and began to follow CNA #1 while being verbally aggressive. At some point, the CNA turned around and engaged verbally with the resident causing other staff members to respond by assisting with redirection of the resident and staff member. The following concerns were identified: a. Review of the significant change MDS assessment dated 11/2/24 showed resident #72 had a BIMS score of 5 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and depression. b. Review of the camera footage without sound from 10/25/24 on 12/12/24 09:52 AM showed CNA #1 walked down the hall toward resident #72's room with resident #72 walking behind him. CNA #1 entered resident #72's room. The resident entered the room and the CNA	F 600		

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 12/12/2024

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 600	Continued From page 2 exited with a mechanical lift. Shortly after, the resident exited the room and walked in the same direction the CNA walked, toward the common area by the nurses' station. The CNA went to another room off camera, and the resident went to a table in the common area. The CNA returned to the common area and the resident got up from a table and walked toward MA-C #1 at the nurse's cart. At that time, the CNA began pointing at the resident followed by the resident pointing at the CNA. The CNA and resident moved toward one another, becoming very close to each other, while additional staff members arrived in the common area and attempted to get between the resident and CNA. The additional staff members assisted the resident out of the common area, toward his/her room, while the CNA continued to move toward the resident. Continued review showed the additional staff members attempted to prevent CNA #1 from moving toward resident #72. Additional staff members were able to separate the CNA and the resident; however, the CNA got free from them and headed toward the resident, who was down the hall. Staff continued to attempt to redirect the CNA and eventually, were able to get him to go toward the nurses' station. c. Interview with CNA #2 on 12/11/24 at 6:51 PM revealed CNA #2 was in the restorative room when she heard some yelling. CNA #2 went down the hall where she observed resident #72 and CNA #1 positioned chest to chest and yelling at each other. CNA #2 revealed multiple staff attempted to get CNA #1 and the resident away from each other. CNA #2 revealed after staff were able to get distance between them, the resident started making noises which upset CNA #1 again and, at one point, CNA #1 started running toward the resident with his fists up. When the resident was redirected to his/her room, s/he wanted to	F 600	F600- Freedom from Abuse, Neglect, and Exploitation 1-5) Regarding incident 1. CNA#1 no longer works at the facility.Regarding incident 2, Resident #71is no longer able to walk indepenently so can not attempt to enter another's space with out assistance. Regarding incident 3, Resident # 72 has completed medication adjustments and no longer reacts as aggressively towards others. Resident #29 still declines to talk about the incident involving Resident #72. It is noted that R29 often becomes frustrated when things don't happen as they wish. R29 has started taking an antidepressant but declines counseling or other psychiatric review. Regarding incident 4, Resident #131 no longer lives at the facility. Regarding incident 5, Resident # 67 is no longer able to ambulate with out assistance. While no other residents were directly affected in each incident reviewed, WRC has identified the potential for a similar incidents to occur that could potentially affect all residents. WRC will provide mandatory education to all current staff of the facility. Education will include de-esculation, interpersonal relationship skills, conflict resolution,Trauma informed care, and policy updates. WRC recognizes the potential for all staff to have similar occurance and will include this education for all incoming staff. Administrator or designee will audit this process bi-weekly for 6 months. Audits will be reported at a monthly QAPI meeting. QAPI committee will review and make recommendations until substantial compliance is reached	1/17/25

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 12/12/2024

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 600	Continued From page 3 call the police on CNA #1. Further interview revealed she did not recall specific phrases stated by either the resident or CNA #1; however, she revealed both were using a lot of profanity. d. Interview with RN #1 on 12/11/24 at 7 PM revealed resident #72 had been agitated that day and when the RN came out of the nurse's station, the resident was by the door. The RN revealed the resident made comments about wanting to leave the facility. The RN revealed approximately an hour later, she was giving report and could hear CNA #1 speaking in a loud voice saying "Get the F out of here." The RN revealed the CNA was positioned very close to resident #72 and was "in [his/her] face." The RN revealed the resident was making inappropriate comments and noises toward CNA #1 and the CNA "went after [him/her]." At that time, the RN attempted to stop the interaction by pulling the CNA away; however, he broke away and another staff member attempted to stop the CNA. The RN revealed she and another staff member were eventually able to get the resident to his/her room and get the resident calmed down. The RN revealed the CNA was the aggressor and charged at the resident using profanity and yelling loudly. The RN stated CNA #1 was using more physical intimidation versus verbal threats; however, the CNA did repeatedly tell the resident to "get the F out here." Further interview revealed the resident did not seem afraid of the CNA and was more worried other staff would be upset with him/her; however, the resident did say s/he wanted to call the cops. e. Interview with CNA #3 on 12/11/24 at 7:09 PM revealed during the incident, she was in a resident room down the hall, by the pool table, and she heard screaming going on. CNA #3 walked out, observed CNA #1 yelling at resident #72, and observed other employees were	F 600		

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 12/12/2024

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 600	Continued From page 4	F 600		

separating them. CNA #3 revealed the resident was making inappropriate noises toward CNA #1 and calling the CNA names which caused CNA #1 to attempt to charge toward the resident with his hand in a fist. CNA #1 was telling the resident to "go back to [his/her] F-ing room" and CNA #3 remembered CNA #1 cursing at the resident. CNA #3 revealed the resident was angry when CNA #1 was saying things and the resident was trying to push through staff. Further interview revealed the resident was angry all day after that; however, s/he did not verbalize any fear.

f. Interview with CNA #1 on 12/12/24 at 9:06 AM revealed he was assisting the roommate of resident #72 and while getting a hoyer lift, resident #72 was making very upsetting remarks about the CNA assisting the roommate. CNA #1 revealed the resident was trying to prevent him from providing care to the roommate, was using profanity toward the CNA, and was calling the CNA the "N word." CNA #1 revealed resident #72 began following him and, in the past, the resident had been violent. When the resident was following him, CNA #1 got upset. CNA #1 revealed the resident was very alert, very knowledgeable, and very competent. CNA #1 stated he tried going to the nurses' station to get assistance; however, the doors were locked because the nurses were afraid of the residents. CNA #1 stated he went into the bathroom and when he came out of the bathroom, he realized it was himself and the resident, alone. CNA #1 revealed he had to shout at the resident because he felt the resident was going to do something. CNA #1 revealed he eventually told the resident "Do not call me the f-ing N word." CNA #1 revealed the other staff held him back, which he felt was very disturbing. CNA #1 stated he felt embarrassed staff were holding him. CNA #1

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 12/12/2024

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 600	Continued From page 5	F 600		

revealed he told the resident to stop calling him the "N word" and the resident continued calling the CNA names. CNA #1 revealed the other staff were all hiding and he felt it was a hostile environment. CNA #1 revealed the resident had attacked other employees and CNA #1 made a report with the police following the incident. After being separated by other staff, CNA #1 was startled and the resident was still calling him names. CNA #1 revealed he walked away from the situation at that time and was escorted to the office. CNA #1 confirmed he was terminated from the facility; however, he stated he did not threaten the resident. CNA #1 revealed the resident wanted to do him harm and the CNA did not want to be intimidated by the resident. CNA #1 revealed he did not request to move to the other unit due to male staff were not allowed to go the other unit.

g. Interview with the administrator and infection preventionist/education specialist on 12/12/24 at 10 AM revealed CNA #1 went after resident #72 and was saying the resident knew better. They revealed the CNA could have walked away at any time and when the resident was still upset, the CNA should have left the area. They revealed the CNA felt the resident was cognitively intact and was purposely antagonizing staff. They revealed on the day of the incident, resident #72 had met with the doctor and did not like his/her doctor's answer, which caused him/her to be upset prior to the altercation with CNA #1. Additionally, the resident had eaten breakfast, and when staff cleared his/her plate, the resident returned, and which also upset the resident because s/he believed s/he did not get any food.

2. Review of an incident report dated 8/10/24 showed resident #73 was resting in his/her bed

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 12/12/2024

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 600	Continued From page 6	F 600		

when resident #71 entered the room and attempted to get in the bed. CNA #1 did not witness the incident; however, she heard a "slap sound," heard resident #71 say "ouch," and heard resident #73 say "get [him/her] out." A mark was observed on the left side of resident #71's face. The following concerns were identified:

a. Review of the quarterly MDS assessment dated 10/26/24 showed resident #71 had short-term and long-term memory impairment and diagnoses which included Alzheimer's disease, anxiety disorder, and depression.

b. Review of the quarterly MDS assessment dated 11/9/24 showed resident #73 had a brief interview for mental status score of 1 out 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia, and anxiety disorder.

c. Review of a progress note for resident #71 dated 8/10/24 and timed 10:13 AM showed "Called to locked unit per CNA. CNA stated [resident #71] was noted walking into another resident's room. While she directed herself to redirect resident, she heard "slap-like" sounds x 2. [Resident #71] was redirected from the room and was noted with erythema to left side of face. Assessed resident. Erythema noted to left side of face. No edema noted. No other skin abnormalities noted. No visible or vocal s/s of pain noted..."

d. Review of a progress note for resident #71 dated 8/11/24 and timed 12:18 AM showed "[Resident #71] is on alert charting related to being post resident on resident altercation with [resident #71] being the receiver from 8/10/24. Light redness noted to Left side of face this evening. [Resident #71] showed no signs or symptoms of fear from other community

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 12/12/2024

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 600	Continued From page 7 members. No signs or symptoms of distress related to altercation noted/reported at this time. No new injuries noted/reported at this time. Staff will continue to monitor..." e. Review of a progress note for resident #71 dated 8/11/24 and timed 8:45 AM showed "...Minimal erythema noted to left side of face. Denies any pain or discomfort at this time..." f. Review of a progress note for resident #71 dated 8/12/2024 and timed 12:40 AM showed "[Resident #71] is on alert charting related to being post resident on resident altercation with ____(resident's name) being the receiver from 8/10/24. Redness to face is resolved at time of assessment..." g. Interview with CNA #4 on 12/11/24 at 6:22 PM revealed the CNA heard resident # 71 say "ow" and heard a slap. The CNA couldn't remember if resident #71 had injuries. 3. Review of an incident report dated 11/3/24 showed resident #72 was upset because his/her meal was not to his/her liking. The resident became verbal aggressive towards staff then walked away. At that time, resident #29 was moving up the hallway in his/her power wheelchair and both residents declined to step around or give room for the other to get by. Resident #72 stepped in front of resident #29 then accused resident #29 of running into him/her. Resident #72 then struck resident #29 with an open hand on the right side of his/her face. The following concerns were identified: a. Review of the significant change MDS assessment dated 11/2/24 showed resident #72 had a BIMS score of 5 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and depression.	F 600		

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 12/12/2024

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 600	Continued From page 8 b. Review of the quarterly MDS assessment dated 10/5/24 showed resident #29 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included anxiety disorder and depression. c. Review of a progress note for resident #29 dated 11/3/24 and timed 6:24 PM showed "[Resident #29] was coming back from dinner in [his/her] power wheelchair. A previously agitated resident walked in path of [resident #29]. [Resident #29] stated "get out of my way." The agitated resident then hit [his/her] ankle on the foot rest of the w/c. The agitated resident then said "ow!' and spun around and smacked [resident #29] on R [right] side of face. [Resident #29] and the other resident were separated. [Resident #29] went to room and was instructed to stay away from aggressive resident. [Resident #29] complied and not sought out [sic] other resident. The other resident has not sought [sic] further interactions with [resident #29]. [Resident #29] was assessed for injury but none noted at this time..." d. Review of a progress noted for resident #29 dated 11/3/24 and timed 6:39 PM showed "... [resident #29] was involved in incident where [s/he] received physical aggression in form of a slap to the R side of face. [Resident #29] was initially upset but has no noted injuries at this time..." e. Review of a progress note for resident #29 dated 11/3/24 at 11:54 PM showed "Victim in resident to resident altercation earlier this evening. Resident initially upset and wanting to know what was being done in regard to incident and asking to press charges. Resident was reassured that staff would do their best to keep [him/her] and aggressor away from each other for safety. Resident agreeable and eventually made	F 600		

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 12/12/2024

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 600	Continued From page 9	F 600		

no further mention of incident. Appears to be anxious but denies being fearful..."

f. Review of a progress note for resident #29 dated 11/4/24 and timed 5:19 PM showed "Resident is on alert charting for having received physical aggression. [S/He] has been out of [his/her] room and has been in a pleasant mood. [S/He] did become anxious when the aggressor came near the nurse station for a soda. [S/He] said, "get [him/her] out of here." The other resident was redirected and no other issues noted. Resident did not raise any concerns about [him/her] other wise [sic] and did not complain of any issues from the incident. [S/He] has been calm and relaxed..."

g. Interview with resident #29 on 12/12/24 at 9:01 AM confirmed s/he was hit by another resident; however, s/he did not want to discuss the incident further.

h. Interview with LPN #1 on 12/11/24 at 8:14 PM revealed resident #72 was very upset that day. The resident began to walk off and walked in front of resident #29. Resident #72 turned around to yell at the LPN and when s/he turned, s/he walked into resident #29's wheelchair. Resident #72 then turned and hit resident #29. The LPN revealed resident #29 was pretty upset and wanted to press charges. The LPN revealed resident #29's face was pink immediately after; however, it did not last. Further interview revealed resident #29 was not afraid of resident #72, just mad at him/her.

4. Review of a facility incident report dated 7/16/24 showed resident #131 came out of his/her room with a garbage can and hit resident #73 in the head, right shoulder, and arm. Staff immediately contained resident #131 and took him/her to his/her room. Residents were kept

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 12/12/2024

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 600	Continued From page 10 separated and RN #2 was called into the unit by the aides. The RN assessed resident #73 for injuries and none were noted. Resident #73 was noted to be shocked and didn't understand what had happened. The following concerns were identified: a. Review of the quarterly MDS assessment dated 11/9/24 showed resident #73 had a BIMS score of 1 out 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia, and anxiety disorder. b. Review of the significant change MDS assessment dated 10/20/24 showed resident #131 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia and depression. c. Review of a progress note for resident #132 dated 7/16/24 and timed 7:05 PM showed "...At approximately 1846 [6:46 PM] this nurse was called into the unit related to an altercation between [resident #131] and another community member. When this nurse arrived in unit other community member was sitting in a stationary chair with back against wall outside of room 326 rubbing [his/her] right upper arm and shoulder. A metal trash can was noted on the other side of the doorway of room 326 and trash was noted on the floor. Staff reported that [resident #131] suddenly came out of room 326 with trash can and began hitting other community member with it. [Resident #131] was in [his/her] room pacing back and forth with CNA...When asked what happened [resident #131] stated "I don't know." When this nurse asked why [s/he] hit the other community member [resident #131] stated "I didn't, maybe you should call 911..." d. Interview with MA-C #1 on 12/11/24 at 6:39 PM revealed resident #131 had been having a lot	F 600		

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 12/12/2024

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 600	Continued From page 11 of behaviors on the day of the incident. Resident #131 was in his/her room and resident #73 was sitting in chair in the common area. MA-C #1 revealed "out of nowhere," resident #131 walked out of his/her room and hit resident #73 with a metal trash can. MA-C #1 intervened right away and notified the nurse. The MA-C revealed resident #73 was shocked and didn't really know what happened. MA-C #1 revealed resident #73 was rubbing his/her arm and face following the incident. e. Interview with CNA #5 on 12/12/24 at 8:31 AM confirmed resident #131 was in his/her room then came out and hit resident #73 with a trash can. The CNA revealed resident #73 was upset; however, s/he did not react to the incident. 5. Review of a facility incident report dated 10/7/24 showed a resident-to-resident altercation occurred when resident #67 began to "shadow box" and pace around the unit following a denied sexual proposition to a staff member. As resident #67 passed resident #71, s/he struck resident #71 in the head. The following concerns were identified: a. Review of the quarterly MDS assessment dated 10/26/24 showed resident #71 had short-term and long-term memory impairment and diagnoses which included Alzheimer's disease, anxiety disorder, and depression. b. Review of the significant change MDS assessment dated 10/26/24 showed resident #67 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia, manic depression, and psychotic disorder. c. Review of a progress note for resident #71 dated 10/8/24 and timed 1:11 AM showed "Aides alerted nurse(s)that resident had been in an	F 600		

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 12/12/2024

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 600	Continued From page 12 altercation with another resident. Just prior to the incident, resident was sitting in a recliner in the community lounge area. Aggressor was observed by staff hitting at the air in front resident's face and made [sic]. It is unknown exactly which side of resident's face where contact was made. Resident did not react or say anything following the incident. Staff immediately separated resident from aggressor. Head to toe assessment completed. No injuries noted. Resident did not respond when asked if [s/he] is afraid. Resident remained standing near exit of unit following incident. Does not appear to be fearful at this time. Staff continued to observe resident for any behavior changes or signs of fear..." d. Interview with CNA #6 on 12/11/24 at 6:06 PM revealed resident #67 had an idea the CNA was his/her significant other and at times s/he would get inappropriate. S/he was walking around the unit saying they should do inappropriate things. The CNA told the resident no and asked another CNA to step in. CNA #6 went to provide one on one care with another resident and had to close the door because resident #67 was upset. After that, CNA #6 heard resident #67 had hit resident #71; however, she did not observe it. Further interview revealed she did not recall resident #71 having any injuries. e. Interview with CNA #7 on 12/11/24 at 6:26 PM revealed resident #67 was very upset and had been inappropriate with another aide. The CNAs switched assignments as a result. The CNA revealed resident #67 was going up and down the unit and hit resident #71. Following the strike, CNA #7 revealed resident #71 was confused; however, s/he can't really verbalize things. The CNA revealed resident #71 seemed confused about why s/he got hit, there were no physical injuries, and the resident was hit on the	F 600		

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 12/12/2024

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 600	Continued From page 13 side of his/her face. CNA #7 was unsure if resident #67 meant to hit resident #71 because resident #67 was upset and was swinging his/her arms. f. Interview with RN #3 on 12/12/24 at 9:30 AM revealed when she went back to assess resident #71, s/he had no response and there was no evidence of an injury. Following the incident, a staff member was placed with each resident to keep them apart. The RN revealed she thought resident #67 was just triggered. Further interview revealed resident #71 did not say much verbally. g. Interview with RN #4 on 12/11/24 at 7:40 PM revealed resident #71 was very demented and s/he did not attempt to protect him/herself from others. She revealed following the incident the resident did not have injuries and did not display fear; however, if resident #71 were in the right state of mind, s/he would probably be fearful of resident #67. 6. Review of the policy titled "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" last revised 11/7/19 showed "...The resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation...It is the policy and practice of WRC that all residents will be protected from abuse and neglect..."	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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 12/12/2024

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 609	Continued From page 14 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on incident and grievance review, resident and staff interview, state survey agency incident database review, and policy and procedure review, the facility failed to ensure allegations of abuse were reported timely for 3 of 12 sample residents (#24, #29, #33) reviewed for abuse allegations. The findings were: 1. Review of an incident report dated 11/3/24 showed resident #72 was upset because his/her meal was not to his/her liking. The resident became verbally aggressive towards staff then walked away. At that time, resident #29 was	F 609		

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 12/12/2024

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 609	Continued From page 15 moving up the hallway in his/her power wheelchair and both residents declined to step around or give room for the other to get by. Resident #72 stepped in front of resident #29 then accused resident #29 of running into him/her. Resident #72 then struck resident #29 with an open hand on the right side of his/her face. Further review showed the allegation was not reported until 11/12/24, 9 days after the incident. 2. Review of a "Resident Grievance Record" dated 11/5/24 showed resident #33 made statements of "I want my table back," "Table mate is being mean to me," and "I don't want to eat because of [him/her]." Further review showed the resident was eating in his/her room as a result. The following concerns were identified: a. Interview with resident #33 on 12/12/24 at 8:58 AM revealed his/her previous tablemate said mean things to him/her and wanted to fight him/her. The statements upset the resident and s/he decided to eat in the unit instead of the main dining room. The resident revealed s/he did not want to return to the main dining room because of what was said to him/her. b. Review of a progress note for resident #33 dated 11/5/24 and timed 12:38 PM showed "... [Resident #33] has been upset this morning, [s/he] refused to eat breakfast and is now refusing to go eat lunch. Upon inspection and a conversation with [resident #33], [s/he] states that [his/her] table mate is mean to [him/her] and [his/her] table mate told [him/her] to go jump off a bridge. Management notified of incident. Staff are having [his/her] tray brought down here so that [s/he] is more comfortable..." c. Interview with the administrator on 12/11/24 at 5:06 PM revealed she believed the	F 609	F609- Reporting of Alleged Violations 1.) WRC recognizes the error in not reporting allegations with R72 and R29 in a timely manner. At the time of this incident all staff authorized to complete reporting were unavailable due to a series of uncontrollable events.WRC has completed registration of an additional individual who can complete required reporting WRC acknowledges that appropriate reporting was not completed for the incidents involving R24 or R33, these incidents were reported internally as grievances and managed as such with review of complaints and documentation on the grievance log. On 1/16/24 these incidents were reported late to the OHLS reporting site. 2.-3.) WRC recognizes the error in 2 incidents being reported as grievances and understands the potential for incidents inappropriately reported as a grievance to affect every resident at the facility. WRC has redesigned the facility grievance log to screen for potential reportable incidents. Additionally a grievance must be reviewed and signed off by 3 individuals to ensure it is not a reportable incident. Review of grievance logs will be audited weekly by the Social Services manager or their designee. Results of audits will be reported to the QAPI committee for review and recommendations for at least 3 months or until substatial compliance is reached	11/27/24 1/16/24 12/24/25

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 12/12/2024

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 609	Continued From page 16 incident was reported as a grievance and was not reported as an allegation of abuse. d. Review of the state survey agency incident database showed no evidence the incident was reported. 3. Review of a "Resident Grievance Record" dated 11/5/24 and signed by resident #24 showed "I do not feel safe in my room with my roommate." Further review showed the resident was interviewed by the facility on 11/6/24 at 7:15 AM. S/he indicated s/he was kicked out of his/her room, "If I don't leave s/he was going to break my neck basically in my sleep" and the "[roommate] is getting worse and more aggressive towards people," which resulted in resident #24 changing rooms. The following concerns were identified: a. Interview with resident #24 on 12/10/24 at 1:27 PM confirmed the resident previously had a roommate until the roommate "flipped out" on the resident. Resident #24 confirmed the roommate threatened to break his/her neck. Further interview revealed the roommate put a foot in front of resident #24's wheelchair and s/he accidentally ran over it, the roommate lunged at resident #24, and staff grabbed the roommate before s/he could harm resident #24. b. Review of a progress note for resident #24 dated 11/5/24 at 7:45 PM showed that "Resident moved to [a different room] in the unit per on call manager approval due to verbal altercation with roommate that was nearly physical. Resident very somber and keeps reporting that [s/he] is sorry and feels [s/he] is at fault. Reassurance provided. Resident was assisted to fill out a grievance form per request. States [s/he] is fearful of his roommate." c. Review of a progress note for [resident	F 609	4.) WRC recognizes the potential for management staff not appropriately following the specific mentioned policy and the affect it could have on all residents of the facility. WRC has developed a reportables reminder tag for all managers to carry that identifies verbiage that could indicate additional investigation needed.	1/13/25

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 12/12/2024

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 609	Continued From page 17 #72] dated 11/5/24 at 6:30 PM showed that s/he "became increasingly agitated and began yelling at [his/her] roommate stating that [his/her] roommate had stolen from [him/her]. Remained agitated and continued to yell ... Resident made statements such as, 'If I'm going down then I'm taking people with me with the knives I have hidden around here.' As this nurse, medication aide and [resident #24] were exiting room, [resident #72] continued to be intrusive and [his/her] foot got caught under [resident #24's] wheelchair. Resident made an attempt to strike [resident #24] on the side of [his/her] face. This nurse was in between both residents and no contact was made." d. Interview with the administrator on 12/11/24 at 5:07 PM revealed the 11/5/24 incident between resident #24 and his/her roommate was not reported as an allegation of abuse. e. Review of the state survey agency incident database showed no evidence the incident was reported. 4. Review of the policy titled "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" last revised 11/7/19 showed "...3. The immediate Supervisor or charge nurse, must then report the incident immediately by personally speaking to (no e-mails, voicemails or texts) the Facility Social Worker, Director of Nursing or Administrator for direction and implementation of additional investigation. The facility (Administrator, Director of Nursing or Social Services Director or other designee) will report the allegation to the Wyoming Office of Healthcare Licensing and Survey (OHLS) immediately, but not later than 2 hours after the allegation is made, if the events that cause the	F 609		

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 12/12/2024

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 609	Continued From page 18 allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury..."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, facility incident and grievance review, and policy and procedure review, the facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 12 sample residents (#24, #33) with reviewed for abuse. The findings were: 1. Review of a "Resident Grievance Record" dated 11/5/24 showed resident #33 made statements of "I want my table back," "Table mate	F 610	F610 Investigate/Prevent/Correct Alleged Violation 1.-2.) WRC recognizes the error in 2 incidents being reported as grievances and understands the potential for incidents inappropriately reported as a grievance to affect every resident at the facility. The incidents involving R33 and R 24 have been reported late to OHLS reporting site WRC has redesigned the facility grievance log to screen for potential reportable incidents. Additionally a grievance must be reviewed and signed off by 3 individuals to ensure it is not a reportable incident. Review of grievance logs will be audited weekly by the Social Services manager or their designee. Results of audits will be reported to the QAPI committee for review and recommendations for at least 3 months or until substatial compliance is reached 4.) WRC recognizes the potential for management staff not appropriately following the specific mentioned policy and the affect it could have on all residents of the facility. WRC has developed a reportables reminder tag for all managers to carry that identifies verbiage that could indicate additional investigation needed.	1/16/25 12/24/24 1/13/25

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 12/12/2024

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 610	Continued From page 19 is being mean to me," and "I don't want to eat because of [him/her]." Further review showed the resident was eating in his/her room as a result. The following concerns were identified: a. Interview with resident #33 on 12/12/24 at 8:58 AM revealed his/her previous tablemate said mean things to him/her and wanted to fight him/her. The statements upset the resident and s/he decided to eat in the unit instead of the main dining room. The resident revealed s/he did not want to return to the main dining room because of what was said to him/her. b. Review of a progress note for resident #33 dated 11/5/24 and timed 12:38 PM showed "... [Resident #33] has been upset this morning, [s/he] refused to eat breakfast and is now refusing to go eat lunch. Upon inspection and a conversation with [resident #33], [s/he] states that [his/her] table mate is mean to [him/her] and [his/her] table mate told [him/her] to go jump off a bridge. Management notified of incident. Staff are having [his/her] tray brought down here so that [s/he] is more comfortable..." c. Interview with the administrator on 12/11/24 at 5:06 PM revealed she believed the incident was reported as a grievance and was not reported as an allegation of abuse and confirmed an investigation was not completed. d. Review of the facility incidents showed no evidence the allegation was investigated. 2. Review of a "Resident Grievance Record" dated 11/5/24 and signed by resident #24 showed "I do not feel safe in my room with my roommate." Further review showed the resident was interviewed by the facility on 11/6/24 at 7:15 AM. S/he indicated s/he was kicked out of his/her room, "If I don't leave s/he was going to break my neck basically in my sleep" and the "[roommate]	F 610		

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 12/12/2024

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 610	Continued From page 20 is getting worse and more aggressive towards people," which resulted in resident #24 changing rooms. The following concerns were identified: a. Interview with resident #24 on 12/10/24 at 1:27 PM confirmed the resident previously had a roommate until the roommate "flipped out" on the resident. Resident #24 confirmed the roommate threatened to break his/her neck. Further interview revealed the roommate put a foot in front of resident #24's wheelchair and s/he accidentally ran over it, the roommate lunged at resident #24, and staff grabbed the roommate before s/he could harm resident #24. b. Review of a progress note for resident #24 dated 11/5/24 at 7:45 PM showed that "Resident moved to [a different room] in the unit per on call manager approval due to verbal altercation with roommate that was nearly physical. Resident very somber and keeps reporting that he is sorry and feels he is at fault. Reassurance provided. Resident was assisted to fill out a grievance form per request. States he is fearful of his roommate." c. Interview with the administrator on 12/11/24 at 5:07 PM revealed that there was not an internal investigation completed related to the 11/5/24 incident between resident #24 and his/her roommate. d. Review of the facility incidents showed no evidence the incident was investigated. 3. Review of the policy titled "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" last revised 11/7/19 showed "...1. Should an allegation of potential resident abuse, neglect, exploitation, misappropriation, suspicious injury of unknown origin be reported, the Facility Administrator or his/her designee will be notified and will initiate an investigation into the	F 610		

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 12/12/2024

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 610	Continued From page 21 allegation..."	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

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 12/12/2024

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 656	Continued From page 22 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility investigation review, and policy review, the facility failed to implement treatment in accordance with the care plan for 1 of 9 sample residents (#48) reviewed for accident hazards. The findings were: 1. Review of the significant change MDS assessment dated 11/2/24 showed resident #48 had short-term and long-term memory problems and diagnoses which included fracture of the right femur, atrial fibrillation, and dementia. The resident had a BIMS score of 3 out 15, which indicated severe cognitive impairment. Review of the care plan last revised on 9/12/24 showed resident #48 was "dependent on staff for all transfers, using a gait belt." The following concerns were identified: a. Review of a progress note dated 10/20/24 and timed 5:30 AM showed "CNA states that resident was being transferred X [times] 1 assist from wheelchair to bed. At this time staff member states that resident was trying to pull [his/her] brief down, and CNA attempted to help resident pull it back up mid-transfer. At this time, resident lost his/her balance and sat down hard on the armrest of the wheelchair. Resident unable to	F 656		

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 12/12/2024

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 656	Continued From page 23 re-state what had happened, stating s/he "just fell, and hit that thing hard", (pointing to the arm of the wheelchair.) Resident was assessed for acute injuries. Resident has facial grimacing, and is observed to be in severe pain when attempting to assist resident back to bed. Resident continued to be in extreme pain when staff attempted to roll resident to either side to put a clean brief on resident." b. Review of a history and physical dated 10/20/24 and timed 11:05 AM showed the resident was brought in by ambulance and was unable to ambulate. The x-ray showed a right hip intertrochanteric fracture. 2. Interview with LPN #2 on 12/12/24 at 9:42 AM revealed that around 5:30 AM to 6 AM the CNA transfered resident #48 from the bed to the wheelchair when the resident's knees buckled and s/he "hit [his/her] crotch on the armrest of the wheelchair." The nurse reported the resident was in the wheelchair when the CNA let her know about the fall. The resident complained of pain in his/her pelvis and was assessed by the nurse. The nurse noted no bruising or internal rotation at that time. The nurse administered the resident's scheduled pain medication and when it did not decrease the resident's pain, the nurse called the resident's daughter who asked the nurse to send the resident to the emergency department. Further interview revealed it was the facility policy for a gait belt to be used for all transfers; however, she revealed there was not a gait belt used for the transfer. 3. Interview with the education specialist on 12/12/24 at 10:34 AM revealed gait belts were to be used for every transfer and staff were educated at orientation, annually, and when they	F 656	F656 Devop/Implement Comprehensive Care Plan WRC acknowledges that the care plan for resident #48 was not followed as written. A gait belt was not used during the transfer of this resident resulting in a significant injury. While this incident affected only one resident the facility recognizes the potential for similar actions to affect all residents. Wrc will provide education to all current direct care staff. Education will include proper use of gait belts during all contact transfers. Observation will be completed weekly by the Administrator or designee for 3 months and include at least 8 residents each week to ensure gaitbelts are used properly. Results will be reported to monthly QAPI committee. WRC recognizes the potential for all direct care staff to have similar occurance and will include this education in orientation for all incoming staff. Administrator or designee will audit this process bi-weeklyl for 6 months. Audits will be reported to monthly QAPI meeting for review and recommendations. Until substantial compliance is reached.	1/17/25

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 12/12/2024

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 656	Continued From page 24 were caught not using gait belts during transfers. 4. Review of the "Safe Lifting and Movement of Resident Policy" revised on July 2017 showed "...4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts...)".	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on incident review, medical record review, staff interview, and policy review, the facility failed to ensure residents were free of accidents for 2 of 9 sample residents (#48, #78) reviewed for accident hazards. This failure resulted in actual harm to residents #48 and #78. The findings were: 1. Review of the significant change MDS assessment dated 11/2/24 showed resident #48 had short-term and long-term memory problems and diagnoses which included fracture of the right femur, atrial fibrillation, and dementia. The resident had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. Review of the care plan last revised on 9/12/24 showed resident #48 is "dependent on staff for all transfers, using a gait belt." The following	F 689	689 Free of Accident Hazards/ Supervision/Devices 1.) WRC acknowledges that the care plan for resident #48 was not followed as written. A gait belt was not used during the transfer of this resident resulting in significant injury. While this incident affected only one resident the facility recognizes the potential for similar actions to affect all residents. WRC will provide education to all current direct care staff. Education will include proper usage of gait belts during all contact transfers. Observation will be completed weekly by Administrator or designee for 3 months and include at least 8 residents to ensure gait belts are used properly. Results will be reported to monthly QAPI committee meeting. WRC recognizes the potential for all staff to have similar occurance and will include this education for all incoming staff. Administrator or designee will audit this process bi-weekly for 6 months. Audits will be reported at a monthly QAPI meeting. QAPI committee will review and make recommendations until substantial compliance is reached	1/17/25

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 12/12/2024

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 689	Continued From page 25 concerns were identified: a. Review of a progress note dated 10/20/24 and timed 5:30 AM showed "CNA states that resident was being transferred X [times] 1 assist from wheelchair to bed. At this time staff member states that resident was trying to pull [his/her] brief down, and CNA attempted to help resident pull it back up mid-transfer. At this time, resident lost his/her balance and sat down hard on the armrest of the wheelchair. Resident unable to re-state what had happened, stating s/he "just fell, and hit that thing hard", (pointing to the arm of the wheelchair). Resident was assessed for acute injuries. Resident has facial grimacing, and is observed to be in severe pain when attempting to assist resident back to bed. Resident continued to be in extreme pain when staff attempted to roll resident to either side to put a clean brief on resident." b. Review of a history and physical dated 10/20/24 and timed 11:05 AM showed the resident was brought in by ambulance and was unable to ambulate. The x-ray showed a right hip intertrochanteric fracture. c. Interview with LPN #2 on 12/12/24 at 9:42 AM revealed that around 5:30 AM to 6 AM the CNA transfered resident #48 from the bed to the wheelchair when the resident's knees buckled and s/he "hit [his/her] crotch on the armrest of the wheelchair". The nurse reported the resident was in the wheelchair when the CNA let her know about the fall. The resident complained of pain in his/her pelvis and was assessed by the nurse. The nurse noted no bruising or internal rotation at that time. The nurse administered the resident's scheduled pain medication and when it did not decrease the resident's pain, the nurse called the resident's daughter who asked the nurse to send the resident to the emergency department. The	F 689		

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 12/12/2024

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 689	Continued From page 26 nurse revealed it was the policy for a gait belt to be used for all transfers however there was not a gait belt used for the transfer. d. Interview with the education specialist on 12/12/24 at 10:34 AM revealed gait belts were to be used for every transfer and staff were educated at orientation, annually, and when they were caught not using gait belts during transfers. 2. Review of the admissions MDS dated 10/26/24 showed resident #78 had diagnoses of a urinary tract infection (UTI) and non-Alzheimer's dementia. Further review showed the resident experienced repeated falls and wandering, and had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. The following concerns were identified: a. Review of a facility incident report dated 10/19/24 showed sometime between 9 PM and 10 PM on 10/18/24 the North patio back door alarm went off. Several aides walked outside but did not find anyone. On 10/19/24 at 12:30 AM the back door alarm went off again, and CNA #8 found resident #8 outside in the fenced patio area. S/he was immediately brought in and taken to his/her room and assessed and warmed up. The resident told staff s/he was going to find his/her spouse in the truck. Further review showed staff reviewed video footage of resident #78 which showed the resident exited the North patio west gate at 10:24 PM "camera time." At 10:47 PM "camera time" two staff members were seen investigating the patio. On 10/19/24 at 1:02 AM "camera time" the resident entered the North patio West gate and entered back on the patio. b. Review of a progress note dated 10/19/24 at 7:36 AM showed the resident was assessed by nursing and found to have had wet clothing, deep red knees with a top layer of skin rubbed off, and	F 689	F 689 Free from Accident hazards/ Supervision/ Devices incident 2- Elopement of resident # 78 is acknowledged by WRC as being potentially hazardous. WRC recognizes that an alarm was sounding and staff were not appropriately trained on response to the alarm. Also acknowldeges the potential of this same concern for any resident residing at the facility. WRC will develop an audible alarm policy defining expectations of response when an alarm is heard. Education of policy and expectations will be provided to all current staff. Administrator or designee will conduct weekly observation of alarm responses in at least 4 areas on each end of the building. Results will be presented to the QAPI committee monthly meeting. WRC recognizes the potential for all staff to be responders to alarms and will include this policy and expecations in orientation for incoming staff. Administrator or designee will audit to ensure new staff are receiving this education bi-weekly for 6 months. Audits will be reported at a monthly QAPI meeting. QAPI committee will review and make recommendations until substantial compliance is reached	1/17/25

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 12/12/2024

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 689	Continued From page 27 a bruised second toe on his/her left foot. A wanderguard was placed on the resident's right wrist. c. Review of the care plan dated 10/19/24 showed the resident was an elopement risk/wanderer, disoriented to place, had a history of attempts to leave the facility unattended, impaired safety awareness and wandered aimlessly. d. Interview with the facility administrator on 12/11/24 at 5:57 PM revealed there was not clear video footage of the resident leaving or returning to the building, and there was no longer any video footage to review. e. Interview with the facility administrator on 12/12/24 at 11:24 AM revealed the policy for door alarms was to go and visually check the area. The administrator revealed the staff had not been aware of the resident's elopement, a headcount was not performed, and she could not explain how the resident was gone that long. Further, the administrator revealed the facility policy addressed how to search for a resident that is known to be missing but did not address steps to be taken when doors were alarmed. 4. Review of the "Elopement and Missing Resident" policy revised on 4/2019 showed the policy did not address steps to take when the doors are alarmed. 5. Review of the "Safe Lifting and Movement of Resident Policy" revised on July 2017 showed "...4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts...)".	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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 12/12/2024

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 758	Continued From page 28 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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 12/12/2024

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 758	Continued From page 29 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure target symptoms were identified and monitored for 1 of 5 sample residents (#36) and failed to ensure PRN orders for psychotropic medications were limited to 14 days for 1 of 5 sample residents (#67) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 11/9/24 showed resident #36 had a BIMS score of 9 out 15, which indicated moderate cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, depression, and schizophrenia. The MDS showed the resident had a mood score of 0, which indicated no signs or symptoms of depression, and there were no behaviors exhibited. Further review showed the resident received antipsychotic medication and antidepressant medication during the look-back period. Review of the physician orders showed the resident received risperidone (antipsychotic) 0.5 mg by mouth daily at bedtime for mood disorder due to known physiological condition with depressive features, Paxil (antidepressant) 30 MG by mouth in the morning for depression, and trazodone (antidepressant) 50 mg by mouth every night for	F 758	F758 Free from Unnec psychotropic Meds/ PRN Use 1.) Resident #36 care plan has been reviewed and specific target symptoms have been added. WRC acknowledges the need to ensure appropriate symptom identification for psychotropic medications. Residents displaying behavioral issues are reviewed at a bi-monthly behavior meeting. WRC will now require that Any need or request for adjustment of psychoactive medication must have documentation in the resident chart indicating behavior and non-pharmacological interventions attempted. All requests must be reviewed by the behavioral team prior to physician being contacted for medication intervention. All residents with orders for psychoactive medications will be reviewed to assure behavioral reason for medication is identified Targeted behaviors to be monitored are appropriately identified and added to the individual care plan. Additionally daily monitoring will be added to the TAR MDS Coordinator or other qualified designee will monitor daily for new orders for psychoactive medications to insure individualized target symptoms are identified. Residents will be audited quarterly during MDS process to assure specific symptoms and targeted behaviors are in place on the individualized care plan and in the TAR. Audit findings will be reviewed monthly by the Behavioral Team and the QAPI will review and make recommendations at monthly meeting for 3 months or until substantial compliance is met.	1/13/25 1/17/25

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 12/12/2024

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 758	Continued From page 30 insomnia. The following concerns were identified: a. Review of the psychotropic medications care plan last revised on 5/29/24 showed the facility should monitor medications for side effects and effectiveness every shift. Further review showed side effects were identified; however, there was no evidence the facility identified resident or medication specific target symptoms to evaluate to the effectiveness. b. Review of the medical record showed no evidence the facility identified or monitored resident or medication specific target symptoms to evaluate effectiveness. c. Interview with the administrator on 12/12/24 at 11:22 AM confirmed there were no specific target symptoms identified for the individual psychotropic medications. 2. Review of the significant change in status MDS assessment dated 10/26/24 showed resident #67 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses including dementia, bipolar disease, a psychotic disorder other than schizophrenia and psychoactive substance abuse in remission. The resident exhibited physical behaviors such as hitting, kicking and pushing 4-6 days per week, verbal behaviors such as screaming or cursing at others daily and other behavioral symptoms such as pacing and screaming daily. The following concerns were identified: a. Review of the physician orders for resident #67 showed the resident had two separate orders for lorazepam (antianxiety) dated 9/17/24 for agitation related to psychotic disorder with delusions due to known physiological condition. The first was for lorazepam 1 milligram (mg) scheduled two times daily. The second was for	F 758	F758 Free from unnec psychotropic meds/ PRN use 2.) WRC acknowledges 483.35(e)(4) PRN order for drugs are limited to 14 days. The facility understands the expectation for ensuring that the attending physician or prescribing practioner must document their rationale and indicate the duration for the PRN order. Resident #67 was identified as having a PRN order continuing with out appropriate rationale documentation. Nurse Manager will contact the physician to obtain appropriate rationale MDS Coordinator or other qualified designee will monitor daily for new orders for PRN psychoactive medications to insure they are discontinued in a timely manner or have appropriate supporting documentation by the physician to allow the PRN medication to be continued. Audit findings will be reported at a monthly QAPI meeting for review and recommendation for atleast 3 months or until substantial compliance is met.	1/17/25

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 12/12/2024

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 758	Continued From page 31 lorazepam 0.5 mg every 2 hours as needed up to a maximum of 2 times in a 24-hour period. The PRN lorazepam did not have an end date indicated. b. Review of the medical record showed no physician documentation or resident specific rationale why the PRN lorazepam should be administered longer than 14 days. c. Review of the MAR for November and December 2024 showed the resident received the PRN lorazepam 18 times. d. Interview with the DON and MDS coordinator on 12/12/24 at 11:41 AM revealed they were aware a physician rationale was needed to continue a PRN psychotropic medication order beyond 14 days and had not realized resident #67 did not have one. 3. Review of the policy title "Drug Regimen Review" January 2019 showed "...5. The attending physician will document in the resident record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated in the resident record..."	F 758		