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Form Approved OMB
No. 0938-0391

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 16146 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, 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. 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Wyoming Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 890 US Hwy 20 South Basin, WY 82410	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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.