

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 07/03/2024
NAME OF PROVIDER OR SUPPLIER Wyoming Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>16146</p> <p>Based on review of incident reports and facility documentation, staff and resident interviews, medical record review, and review of facility policies, the facility failed to ensure the resident was free from verbal abuse by another resident for 2 of 4 allegations reviewed (residents #5 and #7), which resulted in psychosocial harm to resident to resident #5. The findings were:</p> <p>The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 6/20/24.</p> <p>1. Review of the 3/30/24 quarterly Minimum Data Set (MDS) assessment showed resident #6 (perpetrator) had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment and had a diagnosis of Schizophrenia. Review of the 5/18/24 annual MDS assessment showed resident #5 (victim) had a BIMS score of 8 out of 15, indicating moderate cognitive impairment. The following concerns were identified:</p> <p>a. Review of an incident report showed on 6/12/24 resident #5 was walking into the dining room. Resident #6 yelled at the resident Trash! You're nothing but trash! Why don't you get some shorter shorts, you're just trashy! Resident #5 also told staff that resident #6 told him/her if you come near me, I'll hit you. Certified nurse aide (CNA) #1 walked with resident #5 back to the north unit, and the resident was in tears. Review of the facility's investigation findings showed As is often the case on a daily basis, [resident #6] made rude and unnecessary remarks to [resident #5] causing [him/her] to feel emotional distress and fear.</p> <p>b. During an interview on 7/2/24 at 5:04 PM CNA #1 stated resident #6 called resident #5 trashy and stated don't come near me. She stated she walked with resident #5 who was crying.</p> <p>c. Review of the medical record for resident #5 showed the following progress notes: 6/13/24- resident expressed fear of the other resident; 6/14/24- the resident continued to feel anxious and fearful of resident #6; 6/16/24- resident reports s/he feels anxious and fearful of resident #6; 6/17/24- the resident reported s/he continues to feel anxious and fearful of resident #6; and 6/18/24- resident continues to feel anxious when in common areas when resident #6 was around.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>d. On 7/3/24 at 9:14 AM resident #5 was interviewed. When asked if s/he ever had any issues with another resident, the resident replied just with [resident #6]. The resident stated resident #6 called him/her names and was mean to him/her. The resident stated I was scared of [him/her]. The resident stated s/he felt better today because resident #6 was just discharged .</p> <p>e. Resident #6 was unable to be interviewed because the resident was transferred to another facility on 7/2/24.</p> <p>f. During an interview on 7/3/24 at 9:17 AM the administrator confirmed resident #5 was upset after the incident with resident #6. She stated the resident was checked in on weekly by staff and continued to say s/he was fearful of resident #6.</p> <p>2. Review of the 4/6/24 quarterly MDS assessment showed resident #7 (victim) had a BIMS score of 9 out of 15, indicating moderate cognitive impairment. A BIMS dated 7/2/24 showed resident #7 scored 11 out of 15, indicating moderate cognitive impairment. Review of the 4/20/24 quarterly MDS assessment showed resident #8 (perpetrator) had a BIMS score of 15 out of 15, indicating intact cognition. The following concerns were identified:</p> <p>a. Review of an incident report showed on 6/8/24 resident #7 came out of his/her room visibly upset and stated I cannot do it anymore with my roommate .[S/he] just said that [s/he] is going to get a double aught six and blow my head off because I'm a pedophile rapist. The nurse spoke to the resident's roommate, resident #8, who stated s/he told the resident that I ought to get someone to get me a thirty aught six so I can shoot [him/her] in the head . Resident #7 was offered another room and was moved to another room away from resident #8. The facility's investigation findings showed Verbal aggression and abuse was verified in this investigation. [Resident #8] did threaten [his/her] roommate [Resident #7] on the evening of 6/8/24 causing [him/her] to feel scared, unsafe and uncomfortable in [his/her] room.</p> <p>b. On 7/3/24 at 9 AM resident #7 stated s/he moved to the current room about a month ago because resident #8 threatened him/her. The resident stated s/he couldn't take it anymore and s/he was afraid if s/he stayed, it would get physical. The resident stated s/he was happy with the room change.</p> <p>c. An interview with resident #8 was attempted, but the resident was asleep.</p> <p>d. During an interview on 7/3/24 at 11:23 AM licensed practical nurse (LPN) #1 stated resident #7 told her that his/her roommate had threatened to shoot him/her. The resident stated s/he couldn't stay with the other resident anymore. She stated she ensured the resident didn't actually have a weapon. She further stated they moved resident #7 to another room that night and the resident has been doing good since the room change.</p> <p>3. Review of the facility's policy Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations, revised 11/7/19, showed The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation was defined in this subpart .</p> <p>4. The following plan of correction was implemented by the facility by 6/20/24:</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>a. Resident #6 was offered counseling, but refused to see them. The resident was placed on a title 25 hold for transfer to the psychiatric hospital. Resident #7 was moved away from resident #8.</p> <p>b. Facility developed a weekly check-in with all residents to enhance monitoring for abuse.</p> <p>c. Staff completed training on de-escalation and abuse.</p> <p>d. The facility reached out to an outside source for resources on abuse training. The facility developed a library for staff education.</p> <p>e. The facility has an active performance improvement project (PIP) in quality assurance for abuse.</p>		