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	10/24/2025

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. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility incident review, and policy review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 1 of 12 sample residents (#1) reviewed for allegations of abuse. This failure resulted in actual physical harm to resident #1. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had a brief interview for mental status score of 7 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia, osteoporosis, and restlessness and agitation. Further review showed the resident was dependent on staff to roll from lying on his/her back to his/her left and right side, lying on his/her back to sitting on the side of the bed, and transferring to the toilet. Review of the admission MDS assessment dated [DATE] showed resident #9 had a brief interview for mental status score of 9 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Alzheimer's disease. Further review showed the resident had physical behaviors directed toward others 1 to 3 days and verbal behaviors directed at others daily during the look-back period. The following concerns were identified:a. Review of a progress note for resident #9 dated 8/15/25 and timed 8:20 AM showed the nurse was notified, by a CNA, that resident #9's cane had made contact with resident #1's leg which resulted in bruising. The CNA had reported she answered resident #1's call light and was helping the resident to the bathroom when resident #9 came to the other side of the room, yelled shut up, and moved his/her cane toward resident #1 where it made contact with resident #1's right lower leg. The note showed resident #9 initially denied hitting resident #1 with the cane; however, resident #9 then stated s/he didn't mean to.b. Review of a facility incident report and investigation dated 8/15/25 and timed 7:40 AM showed Staff reports in risk management that at approximately 740 am on 8/15/25 [resident #1] was hit in the right lower leg by [resident #9]'s cane. CNA [#1] reports that as she was assisting [resident #1] to the restroom when [resident #9] came to [resident #1]'s side of the room and yelled shut up and swung [his/her] cane making contact with [resident #1]'s right lower leg and causing a bruise. [Resident #1] stated that [s/he] had been talking loudly because [s/he] was waiting for staff to assist [him/her] to the bathroom. At first [resident #9] denied hitting [resident #1] but when reminded that staff had witnessed the incident [s/he] admitted to it stating 'I didn't mean to.' [Resident #9] continued to voice feeling 'tortured and subjected to elder abuse because of the noisy, nasty roommate' . The report showed resident #1 received a bruise to his/her right lower leg, just below the knee, which was approximately the size of a 50-cent piece. Further review showed both resident's confirmed resident #1 was struck by resident #9's cane.c. Review of a Head to Toe assessment dated [DATE] and timed 2:45 PM showed resident #1 had bruising to the front of his/her right lower leg which measured 1.5 centimeters (cm) by 2.5 cm. d. Interview with LPN #1 on 10/23/25 at 4:49 PM revealed she was unsure if the CNA had observed the altercation or if resident #1 had told the CNA about the altercation; however, resident #1 did have bruising to his/her lower leg.e. Interview with CNA #1 on 10/23/25 at 5:46 PM revealed she did not observe the altercation; however, she responded to the room after she heard yelling. Upon entering the room, resident #1 reported resident #9 had hit him/her and resident #1 had a bruise on his/her leg about one inch that was about the size and shape as [resident #9]'s cane.f. Interview with the facility administrator on 10/24/25 at 9:31 AM revealed the facility moved resident #9 to another room which was quieter and both residents were placed on monitoring. Further interview revealed she didn't think the facility did anything specific for a plan of correction for the incident.2. Review of the facility policy titled Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations last revised 1/2025 showed .It is the policy and practice of WRC that all residents will be protected from abuse and neglect. WRC will not tolerate any form of resident abuse and will continually monitor facility policies, procedures, and training programs to assist in preventing abuse .