| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wyoming Retirement Center | 890 US Hwy 20 South<br>Basin, WY 82410 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081<br><br>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:<br><br>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:<br><br>a. Review of the significant change MDS assessment dated [DATE] 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.<br><br>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 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.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 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.<br><br>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.<br><br>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 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.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 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.<br><br>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.<br><br>2. Review of an incident report dated 8/10/24 showed resident #73 was resting in his/her bed 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:<br><br>a. Review of the quarterly MDS assessment dated [DATE] showed resident #71 had short-term and long-term memory impairment and diagnoses which included Alzheimer's disease, anxiety disorder, and depression.<br><br>b. Review of the quarterly MDS assessment dated [DATE] 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.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 .<br><br>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 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 .<br><br>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 .<br><br>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 .<br><br>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.<br><br>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:<br><br>a. Review of the significant change MDS assessment dated [DATE] 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.<br><br>b. Review of the quarterly MDS assessment dated [DATE] 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.<br><br>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 .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 .<br><br>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 no further mention of incident. Appears to be anxious but denies being fearful .<br><br>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 .<br><br>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.<br><br>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.<br><br>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 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:<br><br>a. Review of the quarterly MDS assessment dated [DATE] 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.<br><br>b. Review of the significant change MDS assessment dated [DATE] showed resident #131 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia and depression.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 [ROOM NUMBER] rubbing [his/her] right upper arm and shoulder. A metal trash can was noted on the other side of the doorway of room [ROOM NUMBER] and trash was noted on the floor. Staff reported that [resident #131] suddenly came out of room [ROOM NUMBER] 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 .<br><br>d. Interview with MA-C #1 on 12/11/24 at 6:39 PM revealed resident #131 had been having a lot 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.<br><br>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.<br><br>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:<br><br>a. Review of the quarterly MDS assessment dated [DATE] showed resident #71 had short-term and long-term memory impairment and diagnoses which included Alzheimer's disease, anxiety disorder, and depression.<br><br>b. Review of the significant change MDS assessment dated [DATE] showed resident #67 had short-term and long-term memory impairment and diagnoses which included non-Alzheimer's dementia, manic depression, and psychotic disorder.<br><br>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 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 .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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 . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081<br><br>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:<br><br>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 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.<br><br>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:<br><br>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.<br><br>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 .<br><br>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.<br><br>d. Review of the state survey agency incident database showed no evidence the incident was reported.<br><br>51658<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>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.

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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:<br><br>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.<br><br>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.<br><br>c. Review of a progress note for [resident #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.<br><br>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.<br><br>e. Review of the state survey agency incident database showed no evidence the incident was reported.<br><br>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 ([NAME]) 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 result in serious bodily injury . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>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.

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081<br><br>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:<br><br>1. 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:<br><br>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.<br><br>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 .<br><br>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.<br><br>d. Review of the facility incidents showed no evidence the allegation was investigated.<br><br>51658<br><br>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] is getting worse and more aggressive towards people, which resulted in resident #24 changing rooms. The following concerns were identified:<br><br>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.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>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.

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>d. Review of the facility incidents showed no evidence the incident was investigated.<br><br>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 allegation . |

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| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

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|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>Basin, WY 82410 |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485<br><br>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:<br><br>1. Review of the significant change MDS assessment dated [DATE] 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:<br><br>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.<br><br>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.<br><br>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.<br><br>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 were caught not using gait belts during transfers.<br><br>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 .). |

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|---|---|---|---|
| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

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|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485<br><br>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:<br><br>1. Review of the significant change MDS assessment dated [DATE] 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 concerns were identified:<br><br>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.<br><br>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.<br><br>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 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.<br><br>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.<br><br>2. Review of the admissions MDS dated [DATE] 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:<br><br>(continued on next page) |

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| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

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|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>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.

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 [NAME] gate and entered back on the patio.<br><br>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 a bruised second toe on his/her left foot. A wanderguard was placed on the resident's right wrist.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 .). |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081<br><br>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:<br><br>1. Review of the quarterly MDS assessment dated [DATE] 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 insomnia. The following concerns were identified:<br><br>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.<br><br>b. Review of the medical record showed no evidence the facility identified or monitored resident or medication specific target symptoms to evaluate effectiveness.<br><br>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.<br><br>51658<br><br>2. Review of the significant change in status MDS assessment dated [DATE] 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:<br><br>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 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.<br><br>(continued on next page) |

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| | 535021 | A. Building<br>B. Wing | 12/12/2024 |

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|---|---|
| Wyoming Retirement Center | 890 US Hwy 20 South<br>Basin, WY 82410 |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>c. Review of the MAR for November and December 2024 showed the resident received the PRN lorazepam 18 times.<br><br>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.<br><br>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 . |