STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Health and Rehabilitation	503 S 18th St Laramie, WY 82070

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. 44506 Based on medical record review, staff interview, and review of incident and quality improvement documentation, the facility failed to ensure residents were free from physical abuse by other residents for 2 of 10 sample residents (#2, #5), resulting in harm to resident #5 who suffered a fracture. The findings were: 1. Review of the 2/25/24 admission Minimum Data Set (MDS) assessment showed resident #2 (victim) had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 (significant cognitive impairment). The diagnoses included dementia, COPD, gout, pain and skin cancer. 2. Review of the 4/3/24 comprehensive MDS assessment showed resident #5 (victim) had a BIMS score of 9 out of 15 (moderate cognitive impairment) and diagnoses including diabetes, hypertension and respiratory failure. 3. Review of the 3/26/24 admission MDS assessment showed resident #1 (perpetrator) had a BIMS score of 4 out of 15 (significant cognitive impairment). The diagnoses included dementia, stroke with right sided weakness, and diabetes. 4. Review of an incident report dated 4/26/24 showed a resident-to-resident altercation between resident #1 and resident #5 which resulted in injury to resident #5. Resident #5 stated resident #1 came into his/her room and was agitated. Resident #1 pushed resident #5 backwards and s/he hit their head and sustained a skin tear to the arm. The resident also complained of back pain. Resident #5 was sent to the emergency room where it was determined s/he had a closed fracture of the spinous process of the thoracic vertebra. The report showed resident #1 was redirected and placed on increased supervision. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	5. Interview with the director of nursing (DON) on 5/22/24 at 11:50 AM revealed the facility implemented a quality assessment process improvement (QAPI) program addressing the resident-to-resident abuse that occurred between residents #1 and #5 for failure to protect facility residents from abuse. Resident #1 was placed on increased observation while awake. Review of the QAPI program initiated after the resident-to-resident altercation between residents #1 and #5 showed all residents residing in the community were potentially at risk and the facility provided staff training including behavior management and working with residents with behaviors to decrease the risk of aggression towards other residents and a date of compliance of 5/8/24. 6. Review of an incident report dated 5/9/24 showed staff found resident #1 in the room of resident #2. Resident #2 stated resident #1 hit him/her on the shoulder and resident #1 stated, I'm going to hit [him/her] again. There was slight redness on the shoulder of resident #2. Resident #1 was placed on 1:1 observation while awake and plans were made to transfer resident #1 to another facility as soon as a room became available. 7. During an interview on 5/22/24 at 4:18 PM the DON stated resident #1 was on 1:1 observation and the altercation between resident #1 and #2 occurred at shift change when the resident was unsupervised. 8. Review of the facility investigation from the resident-to-resident altercation between residents #1 and #5 on 4/26/24 showed the facility substantiated the allegation. Further review showed the facility investigation of the altercation between resident #1 and #2 on 5/9/24 was also substantiated.