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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/10/2024 |
| NAME OF PROVIDER OR SUPPLIER Cottonwood Health and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on observation and staff interview, the facility failed to ensure ventilation was working in 7 of 10 resident rooms observed. The census was 48. The findings were:</p> <ol style="list-style-type: none"> 1. Observation of room [ROOM NUMBER] on 10/10/24 at 8:16 AM showed the ventilation in the room was not working. Observation of room [ROOM NUMBER] with the maintenance director on 10/10/24 at 8:58 AM confirmed the ventilation in the room was not working. 2. Observation of room [ROOM NUMBER] on 10/10/24 at 8:20 AM showed the ventilation in the room was not working. Observation of room [ROOM NUMBER] with the maintenance director on 10/10/24 at 8:54 AM confirmed the ventilation in the room was not working. 3. Observation of room [ROOM NUMBER] on 10/10/24 at 8:24 AM showed the ventilation in the room was not working. 4. Observation of room [ROOM NUMBER] on 10/10/24 at 8:26 AM showed the ventilation in the room was not working. 5. Observation of room [ROOM NUMBER] with the maintenance director on 10/10/24 at 8:32 AM showed the ventilation in the room was not working. 6. Observation of room [ROOM NUMBER] with the maintenance director on 10/10/24 at 8:38 AM showed the ventilation in the room was not working. 7. Observation of room [ROOM NUMBER] with the maintenance director on 10/10/24 at 9 AM showed the ventilation in the room was not working, the floor was sticky, and the room smelled of urine. Interview with the maintenance director at that time confirmed the ventilation system was not working in some of the resident rooms. |

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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