STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyoming Retirement Center	**890 US HWY 20 SOUTH , Basin, Wyoming, 82410**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 10/23/25 through 10/24/25. The survey was prompted by complaint intake #2616360. The following common abbreviations are used throughout this document: LPN: Licensed Practical Nurse MDS: Minimum Data Set CNA: Certified Nursing Assistant	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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:	F0600		

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 reverse for further 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
[signature]	Administrator	11/12/25

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F0600 SS = G	Continued from page 1 1. Review of the quarterly MDS assessment dated 8/30/25 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 8/18/25 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.	F0600	F600- Freedom from Abuse, Neglect, and Exploitation The Wyoming Retirement Center aknowledges the occurance of this incident. The facility has updated the internal investigation process to include more direct informational gathering and an area for documentation of education provided at the time of any incident. This internal worksheet has been shared with nurses to assist in gathering of proper documentation. Additionally education will be shared out via Google Form that will provide information to staff and to track documentation of education received by staff. While no other residents were directly affected by this incident the facility recognizes the potential for a similar incident to occur. Resident #9 has had their care plan updated to capture sound as a "trigger" which causes them to become upset and potentially place others in danger. Resident #9 has moved to their own room where they are able to control the noise in their environment. Staff have been provided education regarding the potential affect of noises on people with dementia and updated care plan for Resident #9 to ensure knowledge of triggers. All incidents will be reviewed in an adhoc QAPI meeting the first business day following the incident and followed up on in monthly QAPI review. Monthly review will continue for 3 months or until 6 incidents have occured to ensure substantial compliance is reached.	8/15/2025 11/12/2025 11/18/2025

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F0600 SS = G	Continued from page 2 c. Review of a "Head to Toe Assessment" dated 8/15/25 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..."	F0600		