STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

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

(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 from 2/10/26 to 2/12/26. The survey was prompted by complaint intakes WY000004460, WY000004477, 2605748, and 2670014. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0600 SS = D	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, facility incident investigation review, facility performance improvement plan review, and staff interview, the facility failed to protect the resident's right to be free from verbal	F0600	"Past Noncompliance - no plan of correction required"	

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

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F0600 SS = D	Continued from page 1 abuse by a resident for 1 of 3 incidents of resident-to-resident allegations of abuse reviewed. This failure affected resident #13. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 6/12/25. The findings were: 1. Review of the 9/27/25 MDS quarterly assessment for resident #13 showed the resident was admitted to the facility on 2/1/24 and had a BIMS score of 15 out of 15 (cognitively intact), had a mood score of 1 out of 10; and did not exhibit any behaviors or refusal of care during the look-back period. The resident had a diagnoses which included chronic respiratory failure with hypoxia, anxiety disorder, and depression. Further review of the resident's medical record showed s/he was discharged to an assisted living facility on 12/1/25. Review of the 5/6/25 annual MDS assessment for resident #7 showed the resident was admitted to the facility on 6/14/29 and had a BIMS score of 15 out of 15, a mood score of 4 out of 10, and did not exhibit any behaviors or refusal of care during the look-back period. The resident had a diagnosis of bipolar disorder. Review of a 5/7/25 nurse progress note showed while the resident was participating in a shopping trip when s/he asked to be taken to the hospital. Resident #7 as admitted to the hospital with aspiration pneumonia and was readmitted to the facility on 5/9/25. Review of a nurse progress notes from 5/19/25 through 5/24/25 showed resident #7 had an increase in aggressive and inappropriate sexual behaviors toward staff, refusal of care, and was delusional at times. Review of the facility's incident investigation report showed resident #13 was involved in an altercation with resident #7 on 5/28/25. Resident #13 had asked resident #7 to stop teasing an unidentified resident and resident #7 responded with calling resident #13 a "fat bitch", told him/her to "shut the fuck up", and threatened to "knock [resident #13] fucking teeth out." Resident #13 became visibly upset with resident #7 and responded with "go ahead and hit me then." As more staff arrived in the dining area resident #7 left the area and returned to his/her room. The following actions were taken by the facility: a. Law enforcement was notified following the incident with no citations issued. b. Resident #7 was placed on 15-minutes checks and staffing was increased to ensure resident safety. c. A surveillance monitor was placed outside of resident #7's room to alert staff when s/he exited the room.	F0600		

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F0600 SS = D	Continued from page 2 d. Resident #7's primary healthcare provider was notified and the resident was assessed the day following the incident. A medication regimen review was also requested. e. The facility offered to relocate resident #13 to another room; however, s/he declined and stated s/he was "fine". f. The social services director met with resident #13 three times per week for 1 month to ensure the resident did not suffer any additional trauma related to the incident. g. Education was provided to all staff and managers on 5/29/25 on abuse and neglect. h. Resident safety interviews were conducted with residents throughout the facility. 2. Interview with the DON on 2/12/25 at 11:18 AM revealed resident #7 showed an increase in behaviors after being treated for pneumonia in May. Following the incident resident #7 was diagnosed with an infection, was placed on antibiotics, and the resident's antipsychotic medication was increased. The DON stated resident #7 had not been involved in any further resident-to-resident incidents. 3. Review of a 6/12/25 "Social Services Quality Assurance Committee Report" showed "abuse Allegations Reported in May:" There was one allegation of verbal abuse reported to the State in May: It was resident-to-resident incident. There was a verbal exchange between a male and female resident in the dining room. There was no physical exchange. A camera has been placed in the [gender] resident's hallway to help monitor [his/her] where abouts. Interviews were completed with the [gender] resident involved and with other residents per protocol. No further incidents between these two residents have been noted at this time."	F0600		