STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston County Health Services	1124 Washington Blvd Newcastle, WY 82701

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility incident review, resident and staff interview, and policy and procedure review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 6 sample residents (#50) reviewed for abuse. This failure resulted in actual physical harm to resident #50. The findings were:1. Review of the quarterly MDS assessment dated [DATE] showed resident #50 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, non-Alzheimer's dementia, and asthma. Further review showed the resident required substantial/maximal assistance from staff to move from sitting to lying, lying to sitting, sitting to standing, and chair/bed-to-chair transfer. The following concerns were identified:a. Interview with resident #50 on 12/9/25 at 9:52 AM revealed another resident had gotten upset with him/her and grabbed resident #50 around his/her neck and twisted.b. Review of a facility incident report dated 10/26/25 and timed 11:15 AM showed a staff member was walking by resident #50's room and observed resident #16 on resident #50's side of the room. The staff member reported resident #16 appeared to be hitting resident #50's head while resident #50 was seated in his/her wheelchair. The incident report showed after the residents were separated, resident #50 had redness noted in a few areas of his/her head. Further review showed resident #50 complained of intermittent headache since the incident occurred.c. Review of a Change of Condition progress note for resident #50 dated 10/26/25 and timed 11:20 AM showed .Physical Aggression Received This nurse was called to [resident #50]'s room following NSA [name]'s arrival to the room after hearing yelling. When this nurse arrived, [resident #50] was found seated in [his/her] wheelchair and appeared startled after being the recipient of physical aggression from [his/her] roommate. [Resident #50] was assessed for injury with mild redness noted to the back of [his/her] head, no redness to the shoulders which were the affected areas per witness report . [S/He] and [his/her] roommate have bickered in the past. [Resident #50] had been away from the room for a couple of days, just returned home yesterday afternoon . What nurse thinks is going on with resident is: to have been the recipient of physical aggression. When asked what happened, why did [s/he] get hit by [his/her] roommate, [resident #50] stated I don't know, [S/he]'s got a temper on [him/her]. It's just one of those things. [Resident #50] reported feeling unsafe at the facility with the aggressor as [his/her] roommate. [S/He] reported feeling safe at the facility so long as the aggressor was not [his/her] roommate .d. Review of a progress note for resident #50 dated 10/26/25 and timed 11:36 AM showed .Called and spoke with [resident representative] to notify her of [resident #50]'s physical aggression received from [his/her] roommate. Notified [representative] that the roommate was relocated from their shared room to another residence. She verbalized Poor [resident #50], that poor [guy/gal] just can't catch a break. Notified [representative] [resident #50] is now on regular full VS and neurological observations as [s/he] was hit in the head by [his/her] roommate and she appreciated the update and verbalized understanding to the plan of care. She looks forward to an update as appropriate .e. Review of a Late Entry progress note for resident #50 dated 10/28/25 and timed 2:30 PM showed .This writer was approached by CNA who stated the following, 'I was just talking with [resident #50] who told me [s/he] saw [resident #16] walk down the hall and [s/he] has to see [him/her] in the lunchroom and [s/he] felt a bit uncomfortable. I told [him/her] I was very sorry that happened to [him/her] and I reassured [him/her] [s/he] was safe and that I would tell the proper person to come and talk with [him/her].' This writer thanked CNA for the information and assured her that we will follow up on this information. This writer also overheard [resident #50]'s new roommate telling [resident #50] that [s/he] needed less oxygen, that [s/he] needed to ask for more medicine if [s/he] had a headache, that [s/he] was a lawyer and [s/he] knew all about 'these situations'. This writer and administrator will speak with [resident #50]'s roommate regarding these comments. This writer and administrator went to [resident #50]'s room to speak with [him/her] and [s/he] appeared in good spirits. [Resident #50] was asked if [s/he] felt safe here in the facility and in [his/her] room with [his/her] new roommate and [s/he] stated 'yes.' [Resident #50] did state 'I got hit in the head by that [guy/gal] and [s/he] is out of here now.' [Resident #50] did not express any further comments about the incident that occurred this past Sunday. [S/He] did state 'I was just in the hospital and I'm feeling a bit better now.' This writer and administrator will follow up with social services to come and talk with [resident #50] and Geri psych NP will be contacted to get [him/her] on the schedule to be seen this week. This writer and administrator assured [resident #50] that [s/he] is safe and that we are always here monitoring everybody. [Resident #50] thanked this writer and administrator for

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, resident representative, and staff interview, grievance log review, call light log review, and policy and procedure review, the facility failed to ensure sufficient nursing staff was provided to ensure the highest practicable physical, mental and psychological well-being of 3 of 4 units (Four Corners, [NAME] Creek, Unit 6) reviewed for staffing. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #36 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included left foot drop, lumbago with sciatica, major depressive disorder, and pneumonia. Further review showed the resident was dependent for toilet transfers. The following concerns were identified: a. Interview with the resident on 12/9/25 at 8:27 AM revealed s/he had to wait a long time for the call light to be answered, and meal times were a longer wait time. b. Interview with the resident's representative on 12/9/25 at 11:31 AM revealed the resident would use his/her call light, staff would come in and turn it off and move the rolling table, and the resident was then unable to reach the call light or phone. They reported the resident has been left sitting in feces in his/her recliner due to the extended wait times. Further interview revealed the resident's roommate would often push his/her call light in order to get assistance for the resident because s/he could not reach the call light. c. Observation on 12/10/25 at 4:17 PM showed the resident was sitting in his/her recliner and crying, and reported the bedside table was not placed close enough in front of him/her to reach the call light and phone. d. Review of the facility grievance log showed a grievance was filed on 12/6/25 by the resident's family which stated the resident was found by a family member with his/her bedside table, call light and cell phone out of reach. Further, the resident's call light had been turned off by a CNA who had left to find help to assist him/her, and the CNA did not return to assist the resident while the family member was still in the room. 2. Interview with 7 residents during resident council on 12/9/25 at 10:04 AM revealed the residents were told the average response time for call lights was 7 minutes; however, they reported the call lights are turned off by staff, residents were told the staff will be right back, and they never see them again. 3. Interview with resident #17 on 12/9/25 at 10:15 AM revealed s/he waited 73 minutes for a call light to be answered. 4. Interview with staffing coordinator on 12/11/25 at 10:52 AM revealed there are usually 6 CNAs when the facility was fully staffed, unless staff called off, which happened frequently. 5. Interview with CNA #2 on 12/11/25 at 11:06 AM revealed the facility did not have enough staff to provide cares for residents at all times. Further interview revealed there were times when there was only 1 staff in the locked unit and 2 for the rest of the building. This resulted in residents who were soaked in the morning. She reported there have been times when 1 CNA has been responsible for 27 residents at night. 6. Interview with CNA #1 on 12/11/25 at 11:06 AM revealed there were times when there were only 2 CNAs at night, and the day staff stayed late to help residents so they could go to bed when they wanted, and not have to stay up until midnight because there was not enough staff to help. Further interview revealed she had seen call lights that had been on for over an hour. 7. Review of the call light log for resident #36 showed the call light wait times on 11/16/25 of 49 minutes at 8:37 AM, 11/18/25 of 69 minutes at 6:49 AM, 11/23/25 of 84 minutes at 8:21 PM, and 11/23/25 of 84 minutes at 9:46 PM. 8. Review of the call light log for resident #17 showed call light wait times on 11/23/25 of 35 minutes at 9:13 PM, 12/6/25 of 34 minutes at 8:23 PM, and 12/6/25 of 34 minutes at 8:58 PM. 9. Interview with the DON on 12/11/25 at 1:45 PM revealed she did not have an expected time frame for CNAs to answer call lights. She reported if non-clinical staff answered the light, they would leave it on for clinical staff. Further interview confirmed she has been drilling staff on call lights, and she currently had a contest for staff regarding call light times. Her expectation for staff during the day was to have 2 CNAs on each hall to partner and help each other out, and if staff called out, she would try to replace them and assist the direct care staff. She reported she did not have a facility policy on answering call lights.