

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  535023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/31/2026
NAME OF PROVIDER OR SUPPLIER  Weston County Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This requirement was not met as evidenced by:Based on observation, resident trust account review, Amazon order review, medical record review and staff and resident representative interview, the facility failed to protect residents from misappropriation of resident property for 1 of 3 sampled residents (#2) reviewed for misappropriation of property. The findings were: 1. Review of the 1/14/25 quarterly MDS assessment showed resident #2 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia, non-traumatic brain dysfunction, and meniere's disease. Further review showed the facility managed the resident's funds through a trust account. Attempts to interview the resident were unsuccessful due to cognitive debilities. The following concerns were identified:a. Review of the document titled Business Order Information provided by the NHA on 3/30/26 at 4:30 PM showed an Amazon order was placed for resident #2 on 2/10/25 which included 3 Meta [NAME] virtual reality headsets in the amount of \$399.99 per unit.b. Review of the document titled [NAME] County Health Services Trust Transaction History provided by the patient services coordinator on 3/31/26 at 11:12 AM showed a debit from the residents' trust account dated 2/10/25 in the amount of \$1,878.78 for Amazon purchases.c. Observation on 3/30/26 at 1:45 PM showed 3 Meta [NAME] virtual reality headsets in their original boxes (one opened) in the activities storage room located near the main dining room.d. Interview with the activities director on 3/30/26 at 1:46 PM revealed she did not know who the devices belonged to and they had been stored in the closet since February of 2025. She further revealed the devices required an internet source and she didn't know how to use them.e. Interview with the resident's responsible party on 3/31/26 at 10:15 AM revealed s/he knew nothing about the Meta [NAME] purchase. In addition, s/he did not believe the resident would have been capable of operating the virtual reality devices.f. Interview with the NHA on 3/31/26 at 10:30 AM revealed the resident was obligated to spend down his/her trust account as Medicaid requirement and 3 Meta [NAME] virtual reality headsets were ordered for the resident and possibly some friends to utilize.</p>

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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